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ABSTRACT

Major research findings are synthesized and innovations of current concern to vocational rehabilitation professionals are reported in this paper on national health insurance (NHI) and rehabilitation. Discussion covers the following topics: the concept of insurance, forms of health insurance, issues arising from hearings on NHI, perspectives of congressional staff regarding the probable interface between NHI and vocational rehabilitation services, current major NHI proposals, the Canadian experience with an NHI program, the Connecticut experience with a statewide NHI program, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the nation's single largest health plan. A separate commentary on NHI and rehabilitation by Joseph LaRocca includes discussion of health insurance legislation, rehabilitation recommendations for NHI proposals in the areas of rehabilitation services and facilities, and training vocational rehabilitation agency staff on NHI coverage and benefits. The document concludes with recommendations for NHI in such areas as benefit coordination, reimbursement, financing, administration, training, and research. An annotated bibliography makes up approximately one half the document; the annotations summarize selected substantive detail from the original sources. (TA)

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EMERGING ISSUES IN REHABILITATION

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PERSPECTIVES ON NATIONAL HEALTH INSURANCE AND REHABILITATION

by

Herbert Dorken, Ph.D.

with a Commentary by

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EMERGING ISSUES IN REHABILITATION

AN INTRODUCTION TO THE SERIES

The four comprehensive papers in the EMERGING ISSUES IN REHABILITATION series synthesize major research findings and report on innovations of current concern to vocational rehabilitation professionals:

Independent Living
by Susan Pflueger, with a Foreword by Edward V. Roberts
New Directions in Rehabilitation Outcome Measurement
by Thomas E. Backer, Ph.D.
Perspectives on National Health Insurance and Rehabilitation
by Herbert Dorken, Ph.D., with a Commentary by Joseph LaRocca
Sheltered Industrial Employment
by Carolyn L. Vash, Ph.D.

The Rehabilitation Services Administration Research and Evaluation program (DHEW) has long sought to promote the utilization of research results in order to improve the efficiency and effectiveness of vocational rehabilitation programs. In keeping with that effort, RSA made a grant to the Institute for Research Utilization to identify, select, and summarize the literature in selected areas of urgent concern to the vocational rehabilitation (VR) community. The Grant, Number 22-P-5901 9/3-01, was entitled "Literature Review on Topics of Urgent RSA Need and Concern."

To help ensure the selection of topics relevant to the VR field, the project staff convened a Consumer Panel of representatives of potential user groups: counselors, supervisors, State VR administrators, and planners and policymakers. The panel members nominated, discussed, then ranked in order of urgency, topics which they felt would be desirable for the literature reviews. They also recommended potential subject experts for each topic.

Many rehabilitation practitioners and administrators lack the time to keep up with research developments. They want to know *what* works in a given situation, and *how* to make it work. To facilitate this, each paper was prepared for a specific audience, and written in a clear, readable style. Annotated bibliographies accompany each report.

* * *

Elizabeth L. Pan, Ph.D., Principal Investigator
Judith J. Senkevitch, Project Manager

December 1977

Institute for Research Utilization
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PREFACE

Since the target audience for this paper is rehabilitation personnel, familiarity with state vocational rehabilitation programs is assumed. In view of the wide speculation regarding national health insurance, emphasis has been given to a dialogue on health insurance and the social, economic, and health care implications involved and the probable consequence to the field of rehabilitation.

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Special thanks are due to Mr. Clarence Martin, Executive Director and Counsel, Association for the Advancement of Psychology, who arranged meetings with selected Congressional staff members dealing with Workers' Compensation, the Health Subcommittees of Senate Finance and the House Committee on Ways and Means, and the legislative aides of several Senators closely involved in National Health Insurance proposals and health legislation.

Special thanks are also due to Dr. Charles A. Roberts, Professor of Psychiatry, University of Ottawa, and formerly Principal Medical Officer for Health Insurance in Canada's Department of National Health and Welfare. He provided background information on the history and current status of Canada's national health programs and arranged for me to meet with Mr. M. T. Blue, Consultant on Rehabilitation, Social Services Division of Health and Welfare. Mr. Blue provided information on Canada's federal-provincial vocational rehabilitation programs and arranged meetings with federal staff involved in the development of rehabilitation services to the disabled.

In Connecticut, Mrs. Ann Steele and Dr. Steven Mogul of the State Psychological Association arranged for meetings with officers of The Travelers and the Aetna Life and Casualty Insurance Companies and staff of the State Department of Insurance. Dr. James Peters, State Director of Vocational Rehabilitation for Connecticut and Dr. Gordon H. Cumming, a deputy director of California's Department of Rehabilitation, both provided some helpful perspective on these state programs.

And, finally, there is Dr. Carolyn L. Vash, recently retired Chief Deputy Director, Department of Rehabilitation, California, whom I thank for having involved me in what became a great, though hurried, personal learning experience.

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I. INTRODUCTION

Implementation of the Rehabilitation Act of 1973, which places priority on services to the severely handicapped, will most certainly change the clientele of State Rehabilitation Programs. Persons more disabled physically or mentally, including more severe sensory, locomotion, speech, and cognitive handicaps will now be demanding services. It follows then that the need for restorative services or remedial health care, both to restore function or offset handicap, will be heightened. Will this require State Vocational Rehabilitation (VR) to give increased emphasis and a higher proportion of limited fiscal resources to restorative services? Would this alter the character of State VR Programs? If health care becomes increasingly important, will there be an increased medical direction to the rehabilitation process? If National Health Insurance (NHI) is enacted, will it control health/disability care and will this control spread to related programs such as rehabilitation?

The answers to these questions are not only of importance to the VR client, but to agency staff as they attempt future program planning and speculate about their own professional future. There are, as yet, no absolute answers, but the purpose of this report is to review "insured" or prepaid health care, provide a perspective on this dialogue and describe outcomes which seem desirable and probable.

From 1969, a succession and increasing number of NHI bills have been introduced before each session of Congress. The United States is now the only industrialized nation in the western world which does not have a comprehensive national health service or insurance plan. 1966 saw the introduction of new Social Security programs: Medicare (Title XVIII) to provide health services to the elderly and certain disabled persons, and Medicaid (Title XIX) to provide medical assistance to the categorically needy, those on public welfare. The health and restorative services available to job-injured workers under Workers' Compensation laws are currently quite extensive. Health care is provided for military personnel and extensive health services are available to their dependents, while federal and state employees have a choice of a variety of health insurance plans. Virtually all major employers and all union groups now have group health plans. Indeed, in periods of wage stabilization, more comprehensive health plan coverage is a typically negotiated fringe benefit. These programs and plans have different administrations, different sources of revenue, provide different benefits, and make different fiscal demands upon those eligible for service.

Both the privately and publicly financed programs now entitle about 90% of all residents of the country to some plan of health services. There may be a substantial gap, however, between the services

available through a particular health plan and the actual need of the consumer for health care. A number of persons, for example, only have hospital insurance. And none of the insurance plans are designed for long-term care. The minority without any health insurance include some persons recently unemployed, many migrant workers, and others who are marginally employed or are employed by small employers with a marginal business and, also, some self-employed persons.

Each of the major forms of health care plans has its proponents and opponents. Deriving some form of national consolidation will be a complex task. To better orient the reader to the concept of insurance and the different major forms of health insurance, a working definition of terms common to this field follows.

Premium payment, payroll deduction, and taxation are three common methods by which health/disability insurance or health service plans are prepaid. The price charged is based upon the predicted cost of the services that will be used/provided. Stated otherwise, the prediction is a financial calculation of the risk expected in terms of services to be provided and the charges for them. When the premium is the same for all persons or family groups in an area, the plan is community rated. If, however, a special premium is set either because of a favorable or a high risk expectancy for a particular group of people, then it is experience rated.

Most plans allow the client/patient/consumer direct access and personal choice (freedom of choice) among qualified providers (practitioners), of named professions. Since the client or user has prepaid for the services to a third-party, the insurance carrier, health care organization, or government agency as the case may be, will make a reimbursement or payment for the charges billed. The charge paid for any service may be: an amount not to exceed rate limits, a schedule of maximum allowances; or, on a UCR basis, meaning that it is the provider's Usual charge for the particular service, it is Customary in the area, and it is Reasonable for the service; or, on a pre-set or prospective rate setting basis.

The services covered by the plan comprise a benefit package, while those not covered are exclusions. In all plans, the entitlement of the beneficiary will carry limitations. The limitations can be in terms of a dollar limit or duration of services, or the consumer may be obliged to pay a certain dollar amount of the costs first, the deductible, before the plan makes any reimbursement, or the consumer may have to pay a proportion of the costs, a co-insurance. Most plans do not allow duplication of benefits. When other coverage must be used first, e.g., Workers' Compensation, the plan only provides supplemental or second-dollar coverage. When other plans supplement, the plan benefits are first-dollar coverage. When it is

possible to send on or accumulate all the charges to be forwarded to the third-party for payment, the process is one of pass-through costs.

Some providers may agree with a particular plan not to charge more than a certain fee, so that it may be to the consumer's advantage to seek the services of such a participating provider. Typically, such plans will not pay extra for the services of non-participating providers, the user being billed the difference. When the user may only select from among providers in a specific group practice or health care organization, it is described as a closed panel. Fee for service, a piece-rate method of billing, is the traditional form of billing and paying for health care in private practice. In health plans where potential users subscribe to or enroll in the plan, the professional staff may be paid a salary on contract, with or without profit sharing, which does not vary by the amount of service/visits rendered but by professional standing (specialty credentials), seniority, and whether full or part-time. Or, providers in such plans may be paid on a capitation basis, a fixed amount for each subscriber/user for whom the provider is responsible, regardless of the visits made. Or, the providers may charge the plan on a fee-for-service basis up to the funds available and be responsible for additional services, if any, that may be needed. Providers may also contract to render a block of services to a particular plan.

II. THE CONCEPT OF INSURANCE

Health insurance has become a popularized term. The insurance principle involves risk-spreading and is at its best when it protects against a large loss that is unlikely to happen. Given that the average person makes just over five doctor visits a year, the elderly three times this number, it is obvious we are not dealing with an unlikely event. What is commonly called health insurance is really pre-payment of expenditures. Some generalizing of cost does occur. But for those with pre-existing conditions, who are in hazardous occupations or who are unemployed, health insurance may be impossible to acquire.

In marketing experience, select groups of low risk and apparent good health can be insured for less than the general community. In a competitive market, those who can buy better coverage at less cost, typically do. As the balance of uninsured persons shrinks, the cost progressively rises. From this perspective, those who need coverage the most come to be those who can least afford it, or even acquire it. And if we averaged out the costs for everyone, those with favorable experience plans would have to pay more, perhaps double.

The indigent, the chronically sick, and the handicapped, on the other hand, cannot, for the most part, afford to pre-purchase health care. To the extent they are to have health care, it must be publically funded--funding which comes from those with earnings who can pay. The more closely we address the broad financing problems of health insurance, the more evident it becomes that national health insurance like other social legislation, for whatever else it accomplishes, also involves a measure of income redistribution.

Insurance coverage can be viewed in four layers: minor expenses, such as doctor visits, preventive and ambulatory care; basic protection, generally hospitalization and associated expenses; major medical plans which extend hospital benefits and provide some out-of-hospital costs; and, catastrophic plans with high expense ceilings. The increasingly popular comprehensive plans are essentially a combination of the middle two levels. Whether derived from a collective bargaining agreement or as a fringe benefit of employment, in large part employer paid, these plans are attractive. Such group plans typically return more than 95% of the premium in benefits. For individual insurance, the return is generally little more than 55%.

With the exception of HMO's (Health Maintenance Organizations), FMC's (Foundations for Medical Care) and some IPA's (Individual Practice Associations), health insurance plans are essentially illness

insurance. A common exclusion, for example, is general maternity coverage, since maternity is not seen as an illness or a traumatic accident. But the more widespread coverage for hospitalization leads to greater than necessary hospital use and higher expenses. Aggravating this is the pass-through cost mechanism of the third-party payor. The general focus then is not to the health care of the many but to illness care of the few. The providers, the hospitals, and the pharmaceutical industry are well covered. Not so the generally healthy consumer whose basic need is for early intervention, prevention of illness, and health maintenance.

Rising health care costs are generating increasing public and political resistance. Adding on to the current system will hardly reduce or control costs. Nor would turning over service responsibility to a federal bureaucracy imbue the plan with a better sense of public access, to say nothing of the tremendous dislocation problems. Blue Cross-Blue Shield and all the commercial health insurors would no longer be in business for the design of prepaid plans; the marketing and sales and service as third-party intermediaries would be their business. Rather than augmenting or transfering existing health resources, perhaps the easier solution, the introduction of National Health Insurance, offers the potential for major reorganization of health care delivery--for systemic change.

III. FORMS OF HEALTH INSURANCE

Private health insurance may be grouped into five types: First, are the stock or mutual health insurance companies, the commercial carriers such as Aetna, Metropolitan, Travelers, Prudential, Occidental, and hundreds of other companies, some 320 of which are members of the Health Insurance Association of America. The five companies cited are the largest underwriters of health/disability insurance which indemnifies against the costs of illness or injury.

Second, are the "non-profit" open-panel hospital-medical service plan corporations, such as Blue Cross or Blue Shield. Typically, they have a physician majority in the membership of their Boards. The Blue Cross and Blue Shield Corporations, which are registered in all states, collectively have a premium subscription volume which very closely approaches that of the insurance industry.

Then, third, there are the health maintenance organizations (HMO) like Kaiser-Permanente which function with a closed panel of salaried practitioners who own and control their facilities. They are community based and service radius restricted. In the few cities where they are well established, they are a major health resource. Nationally, their enrollment represents 8% of the population.

Somewhat related are the Foundations for Medical Care (FMC). This newly emerging fourth model, pioneered in California, is beginning to receive close attention among county medical societies. Strong advocates of peer review, the Foundations will contract for health service delivery on a pre-paid at risk basis. Essentially each one is a federation of fee-service practitioners in a competitive health care organization. With the exception of the commercial carriers, the latter insurance plans are generally not regulated by the State Insurance Code but by the Business and Professions Code, Health and Safety Code, or the Government Code, depending on the state.

Finally, fifth, there are the self-insured employee welfare benefit plans of some unions and some large corporations, and several fraternal benefit societies.

Health insurance, broadly stated, has traditionally been a matter of state jurisdiction--and there are some strong pressures to keep it that way. However, in passing the HMO Development Act, PL 93-363, Congress made explicit provision that this federal law would supersede any state law which precluded the formation of an HMO or otherwise prevented this type of organized group practice. In more definitive fashion, the Employee Retirement Income Security Act, PL 93-406, brings all employee welfare benefit plans under federal jurisdiction.

The wide interstate variance in Workers' Compensation laws has brought National Commission inquiries and there is now mounting pressure for passage of S. 2018 (Williams, NJ), the National Workers' Compensation Act, to set minimum national standards, among other things. Other far-reaching and significant health legislation is in place and is intended to break and set ground for national health insurance. The Social Security Amendments of 1972 created the multidisciplinary Professional Standards Review Organizations, first to review hospital services under Medicare but with the intent that the they progress throughout all phases of clinical services.

Placing controls upon the provider has implications not simply for quality assurance, but for cost control. It is the provider essentially who makes the treatment and care decisions which can be cost effective or lead to overutilization or unnecessary services. January 4, 1975 saw enactment of PL 93-641, The Health Services Planning and Resources Act, a sleeper bill that totally revises health planning, requires the creation of Health Service Areas within each state and will control the allocation and use of various categories of federal funds and assures consumer representation in the planning process. Thus, while it may seem that we have been holding an endless debate on national health insurance without progress, the foundations for change are being laid.

IV. THE DIALOGUE ON NATIONAL HEALTH INSURANCE

Various committees of the House of Representatives and of the Senate have held scores of public hearings on the subject of National Health Insurance (NHI). The purpose of these hearings has been manifold: to measure dissatisfaction with the present system--some would say non-system; to entertain innovative proposals for change; and basically to assess the public mood on this topic. There is not a major health profession which has not testified. So, too, have hospital organizations, the pharmaceutical industry, employer organizations, unions and consumer groups.

As the dialogue continues, there appears to be a concurrent move by the insurance industry and by health (medical) care service plans to become more comprehensive in their coverage for those they insure--those who have prepaid their care. They also are attempting to narrow, or at least theoretically close, the gap so that no self-responsible, independent person is not eligible to purchase a policy. Provider groups for their part are subtly, and sometimes not too subtly, attempting to guarantee their professional future. Hospitals are sectionalizing components to convalescent care facilities, ambulatory health care centers and further developing a working/training relationship with schools of the health professions.

The federal and state agencies are also making efforts to reorganize health care administration, health planning, and to exert cost controls. This is yet another measure of responsiveness.

If there has been such extended consideration of NHI, then why don't we have it? Because on almost every issue there is a core of fundamental disagreement. Concepts or principles in the abstract are one thing, but when implemented, may be quite another.

Some Questions

Prevention is a great public health concept. The scientific evidence that fluorides assist in the prevention of tooth decay is clear. But many communities that have tried to fluoridate the public water system have run into a storm of public protest. The evidence on the association of increased risk of lung cancer and heart disease with cigarette smoking is also clear. Yet the growing of tobacco is not only subsidized by public funds, cigarettes are widely advertised and available. How about sex education, family planning, or abortions? Blood transfusions and innoculations, however beneficial, are contrary to some religious beliefs. Unnecessary mal- and over-nutrition are

widespread. So is the use of alcohol. Moreover, trends in the American life style seem to make life for many more precarious and less stable: the increased divorce rate; greater job and residential mobility; pressures for earlier retirement; and high rates of inflation and unemployment. Now, where do we draw the line on preventive endeavors? For all? For whom? Which aspects?

If there is to be NHI, how will it be financed? By premiums, by payroll taxes or deductions, by general revenue or by "earmarked" revenue or some combination? Will it be a set rate for all, or be graded or taxed by income? Will it include unearned as well as earned income, or only a certain level? The result of set rates would be that coverage for the needy would come from general revenue as now and the nation would be community rated. Health care costs substantially more in some areas than others. How you react to "levelling" probably depends on where you live. If some form of assessment is tied to income, then those earning the more would find their health care costing more, perhaps a good deal more, and irrespective of their health status. Would those in the upper income brackets tolerate such a direct subsidy against their resources? Almost all variants have been proposed and there are proponents for each method, but no consensus by far.

Once the revenue has been secured, how will services be paid for? Will providers continue to receive their usual, customary and reasonable (UCR) fee, or will fee schedules be adopted--mandated or negotiated--at rates typical of public service or private practice? Or will they receive a capitation amount--so much for each person in their care, whether well, sick, or very sick? Will providers become salaried? When providers are paid cash, whether directly or via health insurance, only those who pay gain access to care. Decisions to seek health care are, to an extent, economic decisions. If NHI carried universal entitlement, would the care resources be sufficient and would those who now have the access concur that access be equally shared? And who are the recognized providers anyway? Would medicine be the gatekeeper controlling entry to the health care system, designating the services to be provided and holding general supervision over the other professions? The dentists, podiatrists, optometrists, psychologists, nurses, social workers, and others have views on that! Or would the consumer be given freedom of choice, and have direct access to the provider of his/her choice and of any discipline? Will brand name or generic drugs be covered? How much of the range of medical devices and health appliances should be included? Should it vary by age?

Now, with so much undecided, how will the program be administered? Will the only intrusion of government be to pay for the care of the

needy? Should the revenue be collected by the federal government, with the administration by private enterprise or by local or state government? Should health be viewed as a natural resource and health care services established in a manner similar to a public utility? A cynical view is that we have the choice of being ripped off by the private sector or having our lives further controlled by government.

There is a serious concern about assuring access to health care for the handicapped, the unemployed, the needy, and the self-employed. Questions are being raised about escalating, inflationary costs, widespread fraud, and gross variance in level of benefits among state Medicaid programs. If NHI were federalized, would we want to see it tied to Medicare and Social Security? Will Social Security be solvent down the road? Does it provide an equitable return for the taxes collected? Do we even want the return to be equitable? Do we have assurance of stability from general revenue funding, knowing that it is subject to political decisions and incursions? For purposes of NHI, do we amalgamate all health care programs and render health care on a no-fault basis? Should NHI subsume Medicare and/or Medicaid? Should it include all or some of the following: the health/restorative services of Workers' Compensation; Vocational Rehabilitation; the Veterans Administration; the Public Health Service; the CHAMPUS; student health services; state hospitals; county mental health services; and others? Should NHI go beyond administering direct health care services and include: health research--basic and/or applied; the training of health professionals, indentured or with free choice of subsequent location; and public health regulations, such as air pollution, waste disposal, water standards, food inspection, and communicable disease control?

Hopefully this will suffice to illustrate that we are far from consensus on major questions. We may not even have a majority agreement on most. It is obvious that important compromises will have to be reached or there will be no NHI. A lagging national economy adds further hesitancy in the face of uncertainty. An administration committed to NHI, however, might well catalyze public demand and achieve major change on fairly short notice.

Health insurance as we know it today seems designed to evade the clients of State Vocational Rehabilitation agencies. Many plans, especially individual policies, eliminate health care for prior existing conditions, do not provide for comprehensive rehabilitation coverage on either an inpatient or outpatient basis, or have a waiting period, perhaps two years, before care is provided for a prior health disability. The unemployed and marginally employed typically do not have access to health insurance. In any event, the objective of most plans is to enable active treatment but not long-term care.

Most of the NHI proposals to date, while making substantial modifications or provision for acute health services, retain the federal-state Medicaid plan for long-term care for those on categorical assistance and for the indigent. To the extent that acute health services will be beneficial to the VR client, particularly the more severely disabled client, then access to NHI will be a decided asset not only to the client but also to the VR program. To the extent that long-term care, a network of social services, or an income maintenance program are essential, then these resources will probably have to come from a source other than NHI.

There are fifteen Vocational Rehabilitation Services which are provided within the scope of a state agency's program. While the diagnostic services required in Evaluation of Rehabilitation Potential might to some extent be indirectly covered by a health plan as well as some counseling relative to personal adjustment and needed referrals, it is the Physical and Mental Restoration Services (CFR, Ch. XII, Title 45, Section 1361.1(2)) which could be subsumed in major part or at least enhanced by NHI. Not all 15 Physical and Mental Restoration services are covered by any of the bills, so some gaps can be expected.

V. PERSPECTIVES OF CONGRESSIONAL STAFF

What follows represents the consolidated views and comments of five influential staff persons regarding the probable interface between National Health Insurance and Vocational Rehabilitation Services. Because the exchanges were informal, no one is identified. Interviewed in their Washington offices, early June 1977, were staff to the Workers' Compensation Committee of Senate Labor and Public Welfare, the Subcommittee of Senate Finance, and Health Professions Educational Assistance programs in the Senate.

One clear consensus is that there are other priorities more pressing than NHI. These include the resolution of energy problems, tax reform, welfare reform, Social Security financing and mechanisms for cost containment of health services. From this perspective, the view is that these issues need to be resolved before it becomes feasible to address NHI. But obviously these are major issues for which a current, but hardly a permanent solution, can be achieved. Compromises are likely and the pressure of other issues will bring new priorities. There is a surplus of human needs but not of fiscal resources.

Any changes in Social Security and welfare reform could have major implications for those requiring long-term care. Any broadening of these programs, indeed putting the Social Security Trust Fund on a self-sustaining basis, will likely require increased taxation unless the recipient population is narrowed as to age or eligible categories. To the extent taxes are increased, the financing of NHI from new taxation may have less and, perhaps, no appeal. The current thrust of NHI is that it would be a national program. Another resolution would simply have federal law set standards and leave actual implementation to states. The state jurisdiction perspective is well entrenched throughout the insurance industry, whether in the areas of health, life, casualty, fire, auto, or Workers' Compensation insurance. The age and occupational mix varies between states. So too do population density, climate, and economic conditions, all factors which can have a bearing on health.

Generally, it appears that the state administered VR programs, despite wide inter-state variations, have broad Congressional support. They are, of course, funded on a grant basis, leaving allocation and selection of clients to state administration. Service is not based on dollars prepaid nor even a reimbursement for approved services rendered. Most people, however, look upon their health insurance as a benefit package they have bought for use when they need it. Some of this attitude carries over to Social Security pensions, but the pensions are not an annuity bearing a direct relation and return to taxes invested. Many other services may be provided to some but not to all. Public

dissatisfaction with Medicaid appears higher still, partly because of widespread inter-state variance on services provided. There is also mounting concern about dramatically escalating costs--as in public welfare--while those paying essentially are not benefiting.

The political dilemma is to at one time grasp the taxpayers' concern for the public welfare, the public's tolerance/demand for new services, the taxes involved and the degree to which government must administer a direct (clinical) health care service. President Franklin D. Roosevelt came within an ace of combining health insurance with Social Security in 1935. Later, President Truman made an ill-fated attempt to introduce an NHI bill. In 1965, the Kennedy-Johnson Administration settled for Medicare and Medicaid as additions to the Social Security Act. More recently, Representative Wilbur Mills came within one vote of gaining approval for the House Committee on Ways and Means to formulate an NHI bill in 1974, consolidating the many proposals before Congress. No one has come that close since. Even though--perhaps because--it would cut across political constituencies, there are some proponents for consolidating all health programs to achieve better continuity and more efficient health care.

Several of those interviewed think that to the extent health needs were covered through NHI, it would "free up" some state rehabilitation funds. The Health Security Act (Kennedy, Corman) calls for the most comprehensive benefits, and would provide for more medical necessities for rehabiltation than any of the other NHI bills. Vocational rehabilitation is seen, however, as a separate categorical program.

Those rehabilitation agencies, which are recognized as a health service, nevertheless would not come under a health service aegis. Although the agency may provide some medical service, if it is incidental to and not the main purpose of the agency, then it seems likely to remain apart from medical or health controls.

While NHI proposals generally do not explicitly include rehabilitation, they do consistently view Workers' Compensation as a separate program. The Medicare program (Title XVIII) also distinctly avoids duplicating Workers' Compensation. Operationally though, both pay for health services. Separating clearly job related disabilities from the balance is far more complex than it first sounds. For example, there are a variety of occupations where certain toxins and diseases are common, but still in substantial dispute. The effect of cumulative job stress on physical and mental health is also under current debate. It is also well known that the extent of disability varies, independent of the specific injury. Thus, the interface between Workers' Compensation, health insurance, and related health services can be of direct consequence to the rehabilitation field.

VI. CURRENT MAJOR NATIONAL HEALTH INSURANCE PROPOSALS

It does not seem productive to review all NHI proposals. A succession of such bills have been introduced since the 91st Congress. At this point, it appears that if and/or when NHI is adopted, it will not be a complete version of any single present bill. More likely, it will be an amalgamation of those components upon which agreement can be achieved and which are in line with the views of the Administration.

Attempting to forecast the short and long-term cost of NHI is a major dilemma. Congress is daily faced with the progressive cost rise of Medicare and Medicaid (Titles XIX and XVIII of the Social Security Act) far beyond expected levels.

The Health Security Act (Senator Kennedy, Mr. Corman) has the most sponsors to date, appears the most comprehensive in scope, and is the most ambitious. It has been years in development by the Committee for National Health Insurance (CNHI), popularly called the "Committee of 100," which has formulated the plan under the aegis of the AFL-CIO. It would create a federal administration within the Department of Health, Education and Welfare, which as part of the Social Security System, would derive its funding 50% from general revenue and 50% from payroll and income tax. Coverage would be universal and without deductible or co-payment requirements. No private health insurance organizations would be used under the plan. There would be incentives toward organized arrangements for patient care. Medicare would be terminated and Medicaid in states with remnants left would be supplemental to Health Security. Similarly, CHAMPUS (see later section) would provide only those benefits not provided under Health Security. Coordination of Veterans Administration health care programs is a future possibility, but Workers' Compensation is excluded. Nearly the entire range of health care services, including catastrophic coverage would be included.

Of specific interest to Vocational Rehabilitation programs is Section 403, "Funds made available under the Vocational Rehabilitation Act or under Title V of the Social Security Act (Maternal and Child Health) shall not be used, after the effective date of Health Security benefits, to pay for personal health services available under Title I of this Act, but they may . . . be used (a) to pay for institutional services which are either more extensive or intensive . . . or (b) to pay for special medical or other procedures peculiar to Vocational Rehabilitation . . ." (explanation added). Section 27(a)(7) dealing with other professional and supporting services includes in accord with regulations " . . . rehabilitation services furnished by a free-standing rehabilitation center with which the Board has an agreement . . ."

A polar opposite in terms of coverage is the Catastrophic Health Insurance and Medical Assistance Reform Act (Senators Long and Ribicoff, and Mr. Waggoner). It includes a medical assistance plan to federalize Medicaid and a choice of a federally administered plan or an approved private plan. Financing would be derived from a 1% payroll tax--general revenue for public assistance--and encouragement is intended for persons to secure improved basic health insurance to meet the "deductible," the first 60 days in hospital, and $2,000 of medical expenses per family. This plan has considerable political appeal in some quarters. It could eliminate the threat of personal economic disaster due to large expenses for health care. It also is seen as improving Medicaid, costing the least and being an incremental step towards eventual NHI. Its critics say that it would aggravate the inflation of health care costs by removing economic restraint upon high technology procedures without improving the general level of health care. In any event, since benefits would be payable without regard to coverage of services under other public or private plans, it would complement restorative services and probably save the use of some Vocational Rehabilitation funds.

The National Health Care Act (Senator McIntyre and Mr. Burleson) is supported by the Health Insurance Association of America. This bill seeks to strengthen health planning and the development of ambulatory health care centers and its benefits would be phased-in over an eight-year period. Apart from a state plan for the poor, the two private plans (employee and individual) would be open to voluntary purchase with tax incentives. Funding is on a premium basis with a $100 deductible and annual limit of cost sharing for a family of $1,000. The bill includes incentives for training professional personnel on location in areas of need. It creates a state insurance pool and would coordinate malpractice and liability insurance. Medicare would continue and a state plan would be available for the needy which could be selected in place of Medicaid. Vocational Rehabilitation clients insured under this plan would be entitled to full plan benefits which could be supplemented by restorative services.

Among the other major proposals before Congress is the National Health Care Services Reorganization and Financing Act (Mr. Ullman) sponsored by the American Hospital Association. It would abolish Medicare, establish new minimum federal standards for Medicaid, and would limit assistance in other programs, such as child and maternal health, to non-covered benefits. Catastrophic coverage is a plan feature. The American Medical Association and the U.S. Chamber of Commerce have endorsed other plans. None appear to have an adverse impact upon Vocational Rehabilitation, however.

For historical reasons, because it is still considered by many to be a workable compromise and because it almost passed the House Committee on Ways and Means in 1974, the Comprehensive Health Insurance Plan (CHIP) endorsed by the Nixon Administration should not be overlooked. It would have introduced a three-part program, each providing

the same benefits: a private employee-employer plan; a state assisted plan for low income persons; and an expanded Medicare plan. For the private components there were substantial co-payment requirements and a deductible. The bill had an anti-duplication clause, and would not pay for services under Workers' Compensation. Other federal programs for special groups would have continued to operate.

An interesting, and incremental approach is the National Health Insurance for Mothers and Children Act (Mr. Scheuer, Senator Javits). It would provide comprehensive benefits to children and adolescents through age 17 and a full range of maternity related benefits to pregnant women. It would not pay for services covered under other government health programs. Children's preventive care services would be without charge, as well as covered services to the poor. Funding would be derived from a .1% Social Security tax increase collected from wage earners, employers, and the self-employed. This bill would continuously cover only the young, that segment of the population known to use fewer health services than adults or the aged, and for whom preventive services and early intervention could have the most impact.

VII. THE CANADIAN EXPERIENCE

Our northern neighbor, with a territory larger than the USA, but a population one-tenth the size, has many cultural, government, and other parallels to this country. Canada is a federation of ten provinces in which federal/"state" programs are common. Canada has had a national health insurance program in operation for more than 15 years now. It seems that a review of their experience could be instructive and add perspective to the considerations here. Arrangements were made to meet with several current and former officers of the Department of National Health and Welfare in Ottawa, Canada. Noteworthy from the start is that Canada's laws set a federal basis for agreements with the provinces and each administers its own health service program.

In 1957, Canada adopted the Hospital Insurance and Diagnostic Services Act. The provinces were to be matched 50% on net costs for active treatment without time limit. Then in 1961, the Medical Care Insurance Act was passed, again on a 50% matching basis with the provinces, for comprehensive and universal health care. Provincial plans had to meet federal minimum standards and not less than 95% of the population had to be enrolled. Hospital rates were set on a proscriptive basis and outmoded and underutilized hospitals decertified. Professional services rates are essentially annually negotiated fee schedules. Physicians increasingly are salaried, particularly in certain provinces, such as Saskatchewan and Quebec where their administration has developed health centers in areas of need. Salaried medicine is generally considered very well paid, however.

In any event, the pattern of federal standard setting, provincial (public) administration and private service delivery (hospitals and practitioners) with rate controls is nationally established. In the early years, provinces such as Ontario collected premiums for the health service. Finding that inefficient, however, it changed to an income tax method of financing.

Before adoption of the Medical Care Insurance Act (Medicare), the Canada Assistance Plan (CAP) was passed in 1961. CAP also provides 50% federal matching and is very broad in its scope. It includes rehabilitation services. It continues categorical allowances, including unemployment insurance, but it specifically excludes Workers' Compensation and other third-party liabilities. Mental hospitalization was excluded from the Hospital Insurance Act, but CAP provides 50% matching for residential/welfare care so many people have been transferred to Board Homes. Clients undergoing rehabilitation in psychiatric hospitals have been categorized under Welfare, and transferred to the CAP. Similarly, the mentally retarded have been assigned to Welfare and it appears to some that the caliber of services available to both chronic mentally disabled groups has declined.

The Canadian federal government has tried for five years to put a ceiling on Medicare and to renegotiate health insurance. Twenty-eight per cent of the federal budget now goes to health, or about 5% of the GNP compared to 8.7% in the U.S. in 1976. The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977, combines federal dollars for post-secondary education, Medicare, and hospital insurance, and establishes a per capita ceiling subject to cost of living adjustments. The previous legislation, with the exception of fiscal authorizations, continues. The provinces will receive a fixed amount, block grant, per capita plus $20 per capita for special programs such as nursing and home care. This is expected to lead to the conversion of some hospital and mental hospital beds to nursing home beds.

The programs must be universally available and user charges cannot interfere with consumer access. The deterrent concept of co-insurance and deductible has essentially been dropped. Only Alberta and British Columbia still have user charges. There is concern that establishing a ceiling will lead to expanded provincial introduction of deterrents. The federal government, however, will now match on the basis of gross costs. In summary, the net effect of this Act is to peg the costs of health care. All non-health expenses will be transferred to Welfare. Provinces able to save funds from their block grants may allocate these resources elsewhere.

The Vocational Rehabilitation of Disabled Persons Act, 1960, has enabled provision of assessment and restorative services and counseling and employment placement. But it served only those who were potentially employable. Children and the elderly who are handicapped and need certain equipment cannot obtain it under this Act. Federal matching assistance to the provinces is at a 50% level. Workers' Compensation is excluded.

The Social Services Act was submitted to Parliament in June of 1977, with passage not yet completed in December 1977. It would codify the Canada Assistance Plan and has major implications for rehabilitation services. Priorities will be rehabilitation services for the disabled and support or independent living services for the aged and handicapped. It is separate from income support legislation. It is entirely a 50% matching program without limit, hence there will be provincial incentive to shift rehabilitative services to this Act, when adopted. It allows wide provincial latitude for contracting to non-profit agencies, such as crisis centers, but physician and nursing services are not included. All restorative services normally sharable as health services would be excluded from rehabilitation costs. It is planned to transfer prosthetics services to the provinces to increase support for such local industry under this Act. The Act seeks to promote self reliance, including the development of transportation services, subject to a user charge, much like public transportation.

The public funding for rehabilitation in Canada is derived from general revenues: that is, income and corporate tax. However, grants are widely available to private agencies and core grants are currently provided to twelve national agencies in the field (e.g., Canada Council of Rehabilitation Workshops, Canadian National Institute for the Blind, Canadian Association for Mental Retardation, etc.). The private sector's involvement is consistent with the concept of interdependence and distinguishing rehabilitation from a public welfare program. These core grants of $.62 million are projected to increase to $1 million by 1980. In addition project grants of $.5 million have been provided to complement government programs and to assist in gap filling, advocacy, and public opinion feedback. This interrelationship is expected to increase, following passage of the Social Services Act.

Instead of regulations, the laws are implemented through agreements with the provinces. There are no minimum standards. Provinces are encouraged to meet improved objectives, rather than threatening them with "big stick" of regulatory control. Medical rehabilitation is essentially separate from vocational rehabilitation. For the latter, the objective is employment. The quality of rehabilitation programs varies widely among the provinces. Rehabilitation of the alcoholic may be seen as medically oriented in British Columbia, and as a social problem in Nova Scotia, and is funded accordingly. In general, there is an effort to normalize the life of the disabled.

Workers' Compensation is paid for by the employers and provinces and is without federal involvement. It is also separate from rehabilitation.

Thus, the Canadian trend is to encourage provinces to implement and expand rehabilitation programs, fitting provincial needs rather than federal standards and to sustain private agency involvement. Workers' Compensation is viewed as a separate responsibility which should not encroach upon rehabilitation resources per se. And with expanded universal health care, the health service aspects necessary to rehabilitation have progressively been assumed by health services, enabling rehabilitation programs to increasingly concentrate upon vocational rehabilitation. Moreover, when the new Social Services Act is adopted, the matching funds available to rehabilitation will not have the per capita ceiling placed upon health care.

VIII. THE CONNECTICUT EXPERIENCE

As previously noted, the insurance industry is regulated by state law with the responsible state agency headed by an Insurance Commissioner. There is no legal reason why any state could not adopt and pass a state-wide health care act through which it could establish a state health service for direct health care, as distinct from public health or mental health programs or, alternatively, establish minimum standards which any plan/policy must meet and oblige universal coverage. Workers' Compensation does this on a state by state basis for all job-injured employees.

Some fourteen states have mandated the inclusion of certain mental health benefits in all policies underwritten or delivered in the state. Laws have also been passed requiring the recognition of certain licensed practitioners in all health policies. But the first state approach to legislation of comprehensive health insurance was accomplished in Connecticut. In terms of jurisdictional principle, theirs is a fundamentally different approach. Nonetheless it seems a viable option for any state to establish a model rather than close a gap until NHI arrives. It seemed that the implications warranted an on-site inquiry with representatives of the insurance industry and the State's Department of Insurance in Hartford.

In 1975 Connecticut passed its Comprehensive Health Care Act No. 75-616, with some "clean-up" amendments the next year. While a few states have passed limited health insurance laws, such as the "catastrophic" health plan of Rhode Island, the Connecticut law was cited as a model for comprehensive, universally available state health insurance. Indeed, it closely follows the COIL Model Bill drafted by the Conference of Insurance Legislators. Group and individual plans must be available to all interested parties. A key provision was the creation of a risk reinsurance pool established by the insurance industry to make coverage available to those who might otherwise be uninsurable. The law became effective in April 1976, but was not operational until October of that year. Has it affected rehabilitation services?

As of June 1977, there were very few subscribers, no group plans had been sold and less than 1,000 individual plans were in effect: 256 by the insurance industry, and about 500 by the Blue Cross-Blue Shield Services. This in a state of 3.1 million persons. The Traveler's Insurance Company administers The Health Reinsurance Association (risk-reinsurance pool) for the industry. The plan specifically excludes services for job-related injuries which are covered under Workers' Compensation. Doctor visits except for illness and injury do not meet the deductible, hence preventive

care is not included. When first offered, there were also no maternity benefits, as pregnancy is neither an illness nor an injury.

As for rehabilitation, coverage is excluded, not directly, but by plan management. There is a coordination, or non-duplication, of benefits provision whereby health and medical services attributable to auto casualty and Workers' Compensation must be basic. The facility in which the services are rendered must be a medical or hospital setting. This eliminates rehabilitation centers. Services provided by government or in government agencies, whether state hospital or vocational rehabilitation agencies within the State plan, are likewise excluded.

Since the State's Medicaid plan provides more comprehensive coverage than the minimum standards of this Act, there has been no attempt made by the State to buy coverage for this population. Nor would the requirement of a twelve months' wait before prior existing conditions could be covered, enable the plan to qualify for federal financial participation: 50% matching.

In summary, the Connecticut Comprehensive Health Care Act makes health insurance available for those few persons who do not currently have, or otherwise qualify, for such coverage. But they must also be able to afford the per person deductible cost of $200, $500 or $750 for the low, middle, or high option plans, the 20% co-payment in excess of the deductible to a limit of $1,000, and the annual premium. Since statutory provision creates a risk-reinsurance association and empowers it to set premiums state-wide, it is exempt from anti-trust law and can't be challenged with price-fixing. Finally, it is structured to cover health services which are attributable only to sickness or injury, and only where these are not otherwise covered by related insurance or a government service.

Many handicapped persons, unless they have access to group health insurance through employment, are not likely to qualify for an individual health policy. The important point is that this Act requires that insurance be <u>available</u> to all. While it would not cover sickness or injury problems that are the basis of a handicapped condition for the first year, it would cover all other health problems and, after a year, all health problems. The risk pool amalgamation does, then, close a serious gap in the present health insurance market by making health insurance available to the othewide uninsurable. Obviously, however, if the insurance industry intends to see the COIL approach become the basis for state-wide comprehensive health insurance through the private section, then the legislation will need considerable amendment and a serious effort to sell it.

For those handicapped persons without personal coverage or who do not qualify for Medicaid, the COIL plan could be purchased as part of restorative services. Thus, though its present impact upon the State Rehabilitation plan is minimal, the model does have important potential.

IX. CHAMPUS

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is the nation's single largest health plan. Benefits were established by Congress to be not less comprehensive than the broadest high option plan available to federal employees. In all, some 6.31 million persons have this coverage, about 3% of the civilian population, 45% being the dependents of active duty personnel, and 55% being retired military personnel and their dependents. Funding for the CHAMPUS is contained in the annual appropriation allocated in statute by Congress for the Department of Defense.

Though the CHAMPUS coverage is extensive, it is second dollar coverage. Any beneficiary having health insurance by virtue of employment must use those benefits first. Such coverage may, however, be used to meet the deductible and co-payment requirements of the CHAMPUS. Any treatment or care entitlement under Workers' Compensation must also be drawn upon first. In effect this program has a history of "benefit coordination:" that is, non-duplication of benefits, like the "similar benefits" principle followed in the management of Vocational Rehabilitation funds. Regulations also require that where a beneficiary resides within 40 miles of a military base health care facility and the health services needed are available, then such resources are to be used instead of private health care. All this coordination notwithstanding, this is a major program not only in terms of the number of people covered, but also, in terms of its cost. $654 million in calendar year 1974, was paid to civilian facilities and civilian health personnel, an average per beneficiary per annum cost of $104.

The extent to which any of the users of health services under the CHAMPUS have also received state VR services is unknown. Given the comprehensive health benefits available, however, the cost to state agencies for restorative services for those involved in a rehabilitation plan should be minimal. In a sense, the CHAMPUS is national health plan for this discrete segment of our population. It is based upon federal law and the annual budget appropriation by Congress. It could, of course, readily be coordinated into a NHI Act.

The CHAMPUS does have a special Program for the Handicapped, adopted in January 1967 for the dependents of active duty personnel. There is a statutory limit of $350 monthly for medically necessary services and supplies, with a scale of co-payment according to pay grade. It is supplemental to the basic CHAMPUS, requires prior authorization, and is restricted to the severely physically

handicapped or mentally retarded. Once the diagnosis is established and benefits authorized, they may continue for an indefinite duration subject to annual review. The impetus for establishing this Program came from the fact that military personnel, being transient, often did not have access to local services for the handicapped. This special program is quite small, now including some 1,800 persons. The facilities used do not have to be health facilities. Consideration is now being given to developing specific standards for rehabilitation under this Program for the Handicapped.

X. NATIONAL HEALTH INSURANCE AND REHABILITATION

A Commentary by Joseph LaRocca

National Health Insurance (NHI) will have maximum impact on the Federal-State vocational rehabilitation program, and, if legislated, its extension to include rehabilitation for independent living, provided a number of conditions prevail. Principally they are the following:

- Coverage is universal and broad for all Americans regardless of income;
- Rehabilitation concepts and operational practices are basic elements of the system;
- Specific provision is made for comprehensive physical and mental restorative services--rehabilitation services-- and for the duration required in each individual situation, as well as for medical services for the acute care phase of health care;
- Comprehensive rehabilitation services are provided as outpatient as well as inpatient services;
- Accredited rehabilitation facilities are included among the health agencies designated to provide inpatient and outpatient services to the disabled.

In January 1977, there were eighteen proposals before the Congress pertaining to some form of National Health Insurance. No one proposal satisfies all of the conditions, listed above, that would bring about maximum impact upon the rehabilitation program. Some bills incorporate more rehabilitation elements than others and in varying degrees. As a result, their impact upon rehabilitation would vary. A few proposals offering individuals opportunity to buy private health insurance at relatively modest cost, but with benefits hedged with coinsurance charges and other limits would, if enacted, have negligible impact upon the rehabilitation program.

The proposals pending in Congress are constantly undergoing change, hence there is no way of making a reasonable assessment of the impact of National Health Insurance upon rehabilitation until one definitive bill emerges. However, two proposals, "The Health Security Act" and "The Catastrophic Health Insurance and Medical Assistance Reform Act," with widely differing provisions in coverage and benefits, are reviewed below with qualified assessment of the impact they would have upon the rehabilitation program.

The Health Security Act

This proposal by Representative James C. Corman and Senator Edward M. Kennedy would provide for the establishment of a national health insurance program covering the entire population and offering a broad and comprehensive range of services. For covered services there would be no cutoff dates, no coinsurance, no deductibles, and no waiting periods. The program would be financed by a Federal payroll tax on employers and employees, a tax on unearned income and self-employment earnings, and by Federal general revenues.

Benefits under this proposal are broad, generous and virtually free of the restrictions found in other proposals. Benefits would include:

- physicians' services, including physical checkups;
- general hospital inpatient and outpatient care;
- psychiatric care in a general or psychiatric hospital--limited to 45 consecutive days of active treatment during a benefit period;
- skilled nursing home care of 120 days per benefit period;
- physicians' psychiatric services limited to 20 visits during a benefit period, except when benefits are provided through group practice organizations, hospital outpatient departments or comprehensive mental health care organizations, in which case there is no limitation;
- medical appliances and equipment, including eyeglasses, hearing aids, and prosthetic devices;
- and services of free standing ambulatory drug abuse and alcoholism centers, family planning centers, and rehabilitation centers.

In the first year of the program, dental services would be available to children under age 15, extended each year to children two years older up to age 25. After seven years, dental care coverage for the rest of the population would be phased in by age or other types of groups.

Free standing rehabilitation centers could qualify as providers of service.

Passage of the Health Security Act proposals would profoundly affect rehabilitation programs as well as other State grant-in-aid programs providing health services or services with health or medical components to disabled people.

First and foremost, federal grants for Medicaid, material and child health, and vocational rehabilitation programs would not include funds for the provision of services obtainable under the Health Security Program. In the 1976 fiscal year, State VR agencies spent over $100 million in State and federal funds for physical and mental restoration services and over $75 million for diagnostic and evaluation services which included some medical and speciality examinations. Assuming that the Health Security program had been in place in the 1976 fiscal year and that the $100 million plus spent for physical and mental restoration services and medical diagnostic services had been available under the Health Security program, then 80%, the Federal share, of such expenditures would not have been forthcoming to the State VR agencies. Hopefully, federal funds would be provided to the State VR agencies for rehabilitation services of a medical nature that were not provided for under the Health Security program. Additionally, federal funds deductible from the State grants by virtue of the medical rehabilitation services being available under the Health Security program would, we hope, not be deducted. The State agencies would then have added funds with which to serve more clients and with which to purchase other essential rehabilitation services such as vocational training, orientation and mobility training, telecommunication and other equipment for clients who are deaf, blind or otherwise severely disabled, etc. These, of course, are budget and policy matters which only the Administration and the Congress can settle.

The provision in the Health Security Act proposal for the cut off of federal funds for medical services would compel use by the State VR agencies of the Health Security Act. In this regard, it is more stringent than the current provision in the Rehabilitation Act regarding the use of Medicare, Medicaid, etc. as a similar benefit for physical and mental restorative services. With respect to Medicare, Medicaid and other medical programs, the Rehabilitation Act and Regulations currently provide that the "State Agency will give full consideration to any similar benefit available under any other program to a handicapped individual to meet, in whole or in part, the cost of physical and mental restorative services . . . except where such consideration would significantly delay the provision of such services to an individual." No such proviso appears in the Health Security Bill.

With its extensive mental health benefits, the National Health Security program would offer mental restoration services to clients of the state VR agencies that few, if any, can now provide with their own resources. The dominant disability for persons served by the rehabilitation agencies is mental illness, accounting for over 30% of its clientele. Under the National Health Security program, not only might more mental restorative services become available to present clients of the state rehabilitation agencies, but, relieved of the financial responsibility of providing these costly mental health services, the state agencies may be able to serve more persons disabled by psychotic and psychoneurotic disorders. Also, the mental health services provided under the National Health Security program would be an invaluable resource for the state rehabilitation agencies should their programs be expanded to include rehabilitation for independent living. Many people requiring rehabilitation services for independent living are in the upper age groups and mental problems often accompany their physical infirmities.

The Rehabilitation Act of 1973 made provision, among other things, for post-employment services--services to be provided after clients have been rehabilitated to assist those who need such services to maintain employment. As the VR program directs its efforts to serving increasing numbers of severely handicapped people, the planning for and the provision of post-employment services become more important elements of the state VR agencies' services. Often these are expensive services of a medical nature and, in some instances, essential for life support. State rehabilitation agencies have been concerned with how to provide post-employment services and at the same time maintain intake of new cases with relatively little increase in funds available to them. The national health insurance program proposed under the Corman-Kennedy bill could help in this rehabilitation area.

Under the Corman-Kennedy bill, Medicare would be terminated and the assets and liabilities of both Medicare trust funds would be transferred to the health security fund. A recent study by the Urban Institute found limited utilization by VR counsellors of Medicare for the physical and mental restoration services required by recipients of monthly Social Security disability benefits undergoing vocational rehabilitation. (Urban Institute, 1976, p. 47) The reason: coverage under Medicare for recipients of disability benefits does not take place until such recipients have been entitled to disability benefits for two consecutive years. Since referral to the VR agency is part of the initial application procedure for disability benefits, Medicare coverage is not available at the time of referral not, generally, when the Individualized Written Rehabilitation Program (IWRP) is formulated and initiated. In 1976 the state VR agencies spent almost $15 million of Trust Fund dollars for physical and mental restoration services for recipients of disability benefits

undergoing rehabilitation. Presumably, under the Corman-Kennedy bill recipients of disability benefits would qualify immediately for medical and restorative services.

As indicated earlier, the State Medicaid programs would be affected by the proposed Health Security program which would cover most of the services now provided to the poor by Medicaid. This changeover from Medicaid to the proposed Health Security program would facilitate rehabilitation planning and the provision of service by the State rehabilitation agencies to people in economic need since the rehabilitation agencies would not be faced with the same obstacles and deterrents that now exist with regard to Medicaid usage.

Deterrents to the use of Medicaid are now many and vary from state to state. They are:

- the requirement in some states that the "first dollar" be spent by the VR agency since the federal matching ratio in the rehabilitation program is more advantageous to the state than in the Medicaid program;
- cutbacks from time to time in Medicaid services due to funding problems;
- the lack of provision for certain devices essential to rehabilitation, e.g. hearing aids, dentures, repair of prosthetic and orthotic appliances;
- and the long delays in the provision of medical services.

According to the Urban Institute study,

> Counselors cited other problems in the use of Medicaid as a similar benefit, problems related to the quality or adequacy of service and the expeditious carrying through of the client's rehabilitation program. Some physicians do not participate in the Medicaid program. These physicians may be the ones who are most knowledgeable about the rehabilitation program, most involved in serving VR clients who are not eligible for Medicaid, and the ones who are most accessible to the client and the counselor. Thus, if required to utilize Medicaid, the selection of the physician by the client and the counselor in the planning and carrying through of the client's rehabilitation program would be severely restricted. (Urban Institute, 1976, p. 46)

Counselors also reported that some clients find it demeaning to apply for Medicaid, which they regard as welfare. The Corman-Kennedy Bill would establish one program for all people regardless of income. By removing the means test, no one need feel demeaned in accepting the services offered.

The Catastrophic Health Insurance and Medical Assistance Reform Act

This proposal by Representative Joe D. Waggoner and Senators Russell B. Long and Abraham A. Ribicoff would establish three programs:

- a catastrophic illness insurance plan providing health benefits for persons in the general population who have incurred unusually large health expenses;
- a medical assistance plan covering the low income population through a national plan with uniform eligibility standards;
- a program of Federal certification of private health insurance to encourage insurance carriers to make available improved basic private health insurance.

The government catastrophic health insurance program would provide benefits to persons who have already incurred long hospital stays or large medical bills. The program, which would cover all of the population, would be administered through the Medicare program and financed by payroll taxes. Employers could voluntarily elect to provide the catastrophic coverage for their employees under a private plan as an alternative to the government-administered program, and a similar option would be available to self-employed persons.

As to the benefits, the program would cover the same services as the Medicare program and, as under Medicare, the services would be provided under separate hospital insurance and medical insurance parts of the program. Hospital insurance would include hospital inpatient care, skilled nursing facility services and home health services. Medical insurance would include physicians' services, laboratory and X-ray, immunizations, home health services, outpatient physical therapy, medical supplies and appliances and ambulance service.

The three types of services under hospital insurance would be covered after the individual has received 60 days of inpatient hospital care during a calendar year. Once the deductible is met, the period of eligibility for covered services would continue indefinitely

until the individual has been out of both a hospital and skilled nursing facility for a consecutive period of 90 days. If so, the individual would need to meet another 60-day hospital deductible before becoming eligible for benefits again.

Eligibility under the medical insurance part of the program would be on a family basis. The services under medical insurance would be covered for all members of a family after the members together have incurred expenses of $2,000 in a calendar year. Once the deductible is met, the period of eligibility for services would continue indefinitely until the family has incurred expenses of less than $500 in a 90-day period. During the benefit period, all the services under medical insurance would be covered without limitation on the amount of services.

Special provisions would apply to coverage of mental conditions. The hospital insurance part of the proposal would include coverage of inpatient hospital care for mental illness provided in general and mental hospitals. Mental health care services on an outpatient basis would be covered under the medical part of the program. Under a special provision, the amount of expenses for outpatient mental illness care which could be credited toward meeting the $2000 deductible would be limited to a maximum of $500. Once the medical deductible is met, outpatient care would be covered with no limit on the number of visits when provided by a qualified community mental health center. Care by a private psychiatrist would be covered, but limited to a maximum of five visits during a 12-month period, with additional visits covered only if approved in advance by a professional review organization as being necessary to avoid institutional care.

At their option, employers could establish approved private plans as an alternative method of providing coverage for their employees. An approved plan must provide the same catastrophic benefits as the government plan and must meet specified requirements concerning coverage, administration, financing, and other matters. Employees covered under an approved plan would receive the catastrophic benefits under the plan and would not be eligible under the government program.

Self-employed persons could voluntarily establish a private catastrophic plan on a basis similar, in many ways to employer plans. Such a plan would cover the self-employed person and the members of his family and persons covered under them would not be eligible for benefits under the government programs.

The second part of the Catastrophic Health Insurance and Medical Assistance Reform Act, the medical assistance plan for low income and medically indigent persons would be administered through the

Medicare program. It is designed to mesh with the catastrophic plan, as well as other public and private health plans. The program would be financed jointly from federal and State general revenues. The benefits of the program would be available to individuals whose annual family income is below the following amounts without regard to their age, family status, employment, or state of residence:

- individual, $2,400;
- family of two, $3,600;
- family of three, $4,200
- family of four, $4,800;
- family of more than four, $4,800 plus $400 for each additional member.

Families with income higher than the specified amounts could still qualify for benefits under the "spend-down" provision. Under this provision, the family's income for the purpose of eligibility is considered its actual income reduced by the amount of incurred medical expenses the family is legally obligated to pay out-of-pocket: that is, expenses not covered by a private or government plan.

Benefits under this program include:

- inpatient hospital services (60 days in benefit period);
- skilled nursing facilities;
- intermediate care facilities;
- physicians' services--$3 co-payment for each of first 10 outpatient visits per family;
- laboratory and X-ray;
- home health services;
- prenatal and well-baby care;
- family planning and counseling;
- periodic examinations for children under age 18;
- outpatient physical therapy;
- immunizations by regulation;

- medical supplies and appliances;
- ambulance services.

The types of mental health services covered under the medical assistance program would include the same services as under the catastrophic program, including inpatient hospital care, partial hospitalization, and outpatient services, subject to the same conditions and limitations, except for the deductible requirements.

The present Medicaid program would be abolished and replaced by the new program. The Medicare program would continue.

The Catastrophic Health Insurance and Medical Assistance Act would affect rehabilitation in several ways. By abolishing the separate state Medicaid programs and setting up a national health insurance program for low-income and medically indigent persons with uniform eligibility requirements and benefits, a number of the rehabilitation problems associated with the use of Medicaid, discussed earlier, would be obviated. On the other hand, the application process in establishing economic need may be time consuming, interfering with the immediate development and initiation of the individual's rehabilitation program. The process may be demeaning to some people who would view the program as another welfare program rather than a health insurance program.

Some of the services, particularly the mental health services, provided under both the catastrophic health insurance and medical assistance parts of the program are so limited in time and quantity that it would be very difficult to achieve a rehabilitation goal.

Perhaps the greatest problem with the proposal from a rehabilitation standpoint is that it would seem to encourage continued hospital and nursing home care since a disabled individual who is out of the hospital or nursing home for 90 days would need to meet another 60-day deductible before becoming eligible for benefits again. While in the hospital, benefits continue indefinitely. On the other hand, rehabilitation seeks to minimize institutionalization and promote independence.

Finally, the proposal seems to focus on acute short-term medical catastrophies and does not give equal emphasis to the severe chronic illnesses and disabilities which are the major concern of the rehabilitation agencies and facilities.

Rehabilitation Recommendations for National Health Insurance Proposals

Various organizations--the American Congress of Rehabilitation Medicine, the American Academy of Physical Medicine and Rehabilitation, the National Easter Seal Society for Crippled Children and Adults, and the Association of Rehabilitation Facilities--have testified before the Congress on a number of the bills pertaining to National Health Insurance. All have urged that NHI proposals clearly provide for comprehensive rehabilitation coverage on both an inpatient and outpatient basis, that a definition of rehabilitation services be included and that accredited rehabilitation facilities be specifically designated as providers of service. Suggested legislative language to achieve these ends was presented to the Ways and Means Committee by the National Easter Seal Society in its statement on national health insurance, April 15, 1975:

Rehabilitation Services

The term 'rehabilitation services' includes any one or more of the following items or services furnished under a medically prescribed plan and related to the achievement of specific outcomes regarding mental and physical functional capacity or the prevention of deterioration in the disabling condition of the patient:

(1) Physician services, including diagnostic and therapeutic services;

(2) Physical therapy, occupational therapy, and other medically necessary therapies;

(3) Speech therapy, audiology, and vision services;

(4) Prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic or orthotic devices;

(5) Social and psychological services;

(6) Nursing care provided by or under the supervision of a professional nurse;

(7) Drugs, biologicals, supplies, appliances, and equipment, including the purchase or rental of equipment;

(8) Transportation services necessary for the provision of outpatient rehabilitation services; and

(9) Such other services as are medically necessary for the mental and physical restoration of the patient, or the prevention of his deterioriation, and are ordinarily furnished by a hospital, SNF, rehabilitation facility, or home health agency.

Inpatient hospital rehabilitation services are such rehabilitation services as are certified by a physician as required on an inpatient basis for the medical diagnosis or treatment of the patient based on factors such as the need for direct and continual supervision of the patient and the degree of intensity of the service.

Outpatient Rehabilitation Services

The term 'outpatient rehabilitation services' means rehabilitation services furnished by a hospital, skilled nursing facility, home health agency, or rehabilitation facility, or by others under an arrangement with, and under the supervision of, such hospital, skilled nursing facility, home health agency, or rehabilitation facility, to an individual as an outpatient who is under the care of a physician,

excluding however--

any item or service if it would not be included under subsection (a) if furnished to an inpatient of a hospital.

Rehabilitation Facility

The term 'rehabilitation facility' means an institution (or a distinct part of an institution) which--

(i) provides an adequate program of rehabilitation services (one or more of such services) for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify;

(ii) is accredited by the Commission for Accreditation of Rehabilitation Facilities or another qualified accrediting body;

(iii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation facility) to govern the services it provides;

(iv) maintains clinical records on all patients;

(v) if such facility is situated in a State in which the State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency or such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(vi) meets such other conditions relating to the health and safety of individuals who are furnished services by a facility on an outpatient basis, as the secretary may find necessary.

As of this time, none of the NHI proposals incorporate all of the recommended rehabilitation provisions. Inclusion of the rehabilitation provisions would reinforce the role of rehabilitation facilities in national health insurance and insure a comprehensive interdisciplinary service to chronically ill and disabled people, essential for their achievement of maximum functional capacity.

Training VR Agency Staff on NHI Coverage and Benefits

Whatever NHI program may be enacted, it will be essential that VR agency staff, particularly the counselors, have full understanding of the coverage and benefits available under that program. This is inperative if there is to be full utilization of the benefits of the health insurance program in the rehabilitation process. The Urban Institute found, in its study of similar benefit usage, that Medicare, Medicaid, and other programs were not fully utilized because, among other reasons, State VR staff had inadequate knowledge about these other programs. Fifty per cent of the counselors and supervisors participating in the study considered the training they received on similar benefit usage to be inadequate. Moreover, it was felt that, in general, the written materials developed by the State rehabilitation agencies on the utilization of the services offered by the other

programs was of limited value. Only a few State agencies had developed a comprehensive manual. (Urban Institute, 1976, p. 68)

The vocational rehabilitation process is a planned sequence of services directed to the specific needs of the handicapped individual and designed to bring about his or her optimum employment and/or capacity for independent living. The successful outcome of this process will depend primarily upon each of the needed services being provided at the point in the rehabilitation process when required. That is, when the handicapped person is most receptive psychologically and physiologically to the particular service or services, as well as when the provision of the service or services will have the greatest rehabilitative impact. Under a national health insurance program, the counselors will not have the same time controls over the provision of physical and mental restoration services that they now have in the purchase of these services with vocational rehabilitation funds. Another facet of staff training might be the timely utilization of the benefits available under the NHI program in the development and implementation of the individualized rehabilitation programs.

XI. RECOMMENDATIONS FOR NATIONAL HEALTH INSURANCE

The principles advanced here are personal recommendations without any official endorsement. They are proposed as a framework for NHI, not only to illustrate some of the potential critical dimensions but, hopefully, to provide a better grasp of the complexity of the entire issue.

Universality

A national health plan must apply to all legal residents, handicapped or otherwise. To assure that it does, it must be automatic, or required. Care for non-residents should be a personal responsibility or a matter of international agreement.

Phasing

The program should be phased in over a period as long as five years with the phases forecast in advance both to facilitate preparation and minimize dislocation. A sequential implementation should be used to effect a systemic change in health service delivery and in the allocation of health resources. The redirection should be toward optimizing general health in the long run.

The systematic introduction of health education, disability prevention, and health planning should come first and be continuously refined. This should be followed by health enhancement services through, and with the development of, comprehensive ambulatory health care centers and with development geared to community need. Services for acute hospital care are widely available now and should be continued. The next phase should see the decertification of outmoded and unnecessary hospital facilities and, where needed and appropriate, their conversion in whole or part to nursing, convalescent and residential care centers.

Equality

All residents should have equal entitlement to health care regardless of income and without discrimination. The present double standards of quality, all too common between public and private care, would be eliminated. Moreover, necessary health care having been prepaid creates an entitlement intended to place providers and facilities at the service of the consumer. The burden of having to pay for

services as used would largely be removed, as they would be pre-paid, removing the need to make personal economic decisions before receiving health services.

Differentiation

It is essential that distinction be made between: a) active promotion of health and treatment of health disabilities, and b) continuing care for those no longer able to work or live independently. Health services should be in the private sector, meeting general standards and guidelines. Since all residents will have general entitlement, public services for active treatment should be phased out except for people not in civilian life. A complementary program of long-term and supportive community based care, encouraging independent living to the extent possible, should be developed under social welfare auspices.

Benefit Coordination

Within plan limits, active restorative health care should be provided to all persons accepted for state rehabilitation services. Any necessary health care beyond the comprehensive entitlements of the NHI plan would be part of the vocational rehabilitation process. A similar non-duplication should be continued for all CHAMPUS beneficiaries and considered for the Veterans Administration (VA) except for certain highly specialized services. In other words, the CHAMPUS and VA health services would only be supplemental to NHI. The main body of health services now provided under their auspices would be subsumed by NHI. The need for automobile medical expense coverage should no longer be necessary.

Because the separation of the health service benefits of Workers' Compensation programs from cash disability payment could be disruptive and complicate plan administration, it should remain separate from NHI. However, the health care available to job-injured employees should not be less than that under NHI.

Consumer Choice

The consumer must have the option of choice between not less than two alternative and competing health care plans and freedom of choice of practitioner and facilities within health plans. The health services must be provided with guarantee of privileged communication.

Peer Review

The services of all practitioners must be subject to peer review. Since the services rendered, including procedures, drugs, surgery, facilities, appliances and duration of care are in some instances under the prescriptive direction of the provider and in most other instances subject to the discretion and judgment of the provider, then it appears that if they are to be effective, utilization controls should be directed primarily toward the practitioner. To facilitate this review, an individual provider profile must be maintained on computer for all providers authorized to practice.

Continuity

All basic services must be available on a 24-hour basis and an individualized treatment plan formulated upon determination of disability. Individual consumer utilization profiles should be maintained on computer with spot sampling for potential duplication and fraud.

Mental Health

Since emotional or mental disorder is a primary or concurrent problem for the majority of persons seeking health care and vocational rehabilitation services, it is essential that board mental health coverage be an integral component of all health care plans. Note should be taken that most NHI proposals would limit services for mental disorder to less than that available for other health problems. Indeed, since the majority of "doctor" visits are for conditions where emotional distress or mental disorder is a concurrent if not the primary problem, health planning and policy should recognize this lack and consider both psychologists and psychiatrists as primary health care providers rather than back up specialists.

Reimbursement

Hospital and facility per diem and other charges should be based on an annually determined proscriptive rate basis. Similarly, payment for professional services should be annually negotiated. Rates for both hospitals and providers would be determined on a state by state basis. Provider fees or salaries would be statewide, with possible incentives for practice in underserved areas. A salaried basis of practice must be available for those practitioners who elect this form of payment, but with waiver of fees. A mechanism should also be available to providers and group practice organizations

to submit competitive contract bids for services, including payment on a capitation basis--a rate for each person for whose health care the provider is responsible. All rates and fees should be public knowledge.

Financing

Employee-employer payments would be via payroll deduction to cover the cost of the health plan selected. Self-employed individuals would make quarterly payments, and for those without income or with income below federally determined need levels, funds would be transferred from general revenue to a designated NHI account. To facilitate planning, management and competition, health care would be financed on a prepaid basis. Employer, employee, or individual payments would be exempt from taxation at any level. According to state option, the health funds collected federally could be transferred directly to the insurers or via the state.

Administration

Necessary laws and regulations would be adopted to assure all major health professions of independent provider status within the scope of their practice, including, but not limited to: physicians, osteopathic physicians, dentists, podiatrists, psychologists, optometrists, nurse practitioners, and social workers. Similar provisions would be adopted federally to facilitate multidisciplinary group practice. Health planning, designation of underserved areas and oversight of peer review would be a state responsibility. Regulations would provide for federal-state agreements on state plans which substantially exceed the allowable federal minimum program standards.

Provider Status

Each recognized health profession shall develop and maintain a national register of its practitioners, based upon explicit standards and definitions. Listing shall be based on proficiency and credential review by peers, with areas of specialty competence designated. All practitioners must be licensed, registered, or certified, in keeping with the statutes of the state(s) in which they practice.

Training

The training of needed health manpower should be a component cost of NHI. Those who seek public funding or assistance for their

professional training will enter into a return-in-service contract with choice among areas of need. States will annually designate need by community and profession and contracts will be available according to projected consumer needs for health service.

Research

Since the development of new knowledge and technology is unpredictable, and since the products generally have national application, research funding should be derived from a proportionate share of NHI revenues and allocated federally on a competitive basis. To promote additional research or targeted research or specialized research centers, suitable appropriations should be made from the general revenue.

ANNOTATED BIBLIOGRAPHY

Rather than brief annotations which indicate the content nature of each reference, these summaries include selected substantive detail. The intent is that these references serve as an appendix allowing the text to be briefer and focus more on concepts and perspectives. In this regard, the reader's attention is directed in particular to: Ayres; Consumer Reports; Davis; Donabedian; Enthoven; Follette and Cummings; Garfield, et al; Mitchell and Schwartz; Roemer and Axelrod; and the U.S. DHEW Advisory Committee.

Aday, L. "The Impact of Health Policy on Access to Medical Care." Milbank Memorial Fund Quarterly 54, 1976: 215-233.

A social indicator type measure of access to medical care prior to and after the introduction of Medicare and Medicaid showed that the access of the poor, especially those with a regular source of medical care, did improve between 1963 and 1970. Access for middle class and low-income persons with no usual doctor, and high-income persons with regular family physicians, declining considerably over this period. A tentative explanation is that providers have begun to "ration" visits of the well-to-do to serve the influx of low-income patients with newly acquired purchasing power and a backlog of unmet need. Many poor with no previously established source of care continued to experience barriers to entry.

Alander, R. and Campbell, T. "An Evaluative Study of an Alcohol and Drug Recovery Program: A Case Study of the Oldsmobile Experience." Human Resource Management 14, 1975: 14-18.

Studies by W. Winslow, United States government, and J. Vitek show the increased costs associated with problem drinker employees. At Oldsmobile's Lansing plant, changes were compared in on-the-job behavior for voluntary participants in the recovery program and in a control group of abusers. Community resources were used for treatment and rehabilitation services. The control group (N=24) had one full year each of pre- and post-program involvement. Post-program behavior is reported for three experimental groups (total N=117) having follow-up periods of one year, six months to a year, and less than six months, respectively. In all categories, all study groups showed a substantial decline in lost man-hours, sickness and accident benefits paid, leaves of absence, grievances, disciplinary action, accidents, and wages lost. Collectively, wages lost decreased 52% from an employee average

of $3,851 to $1,862. Collectively, the difference was in excess of $250,000. By contrast, the control group showed a substantial increase in sickness and accident benefits, leaves of absence, and disciplinary actions. The average wages lost increased almost 10% to an average of $3,450 per person. Clearly, the program was beneficial for both the company and participating employees.

The study also indicates that the family doctor provides the only care received by 75% of the patients diagnosed as having mental conditions. Thus the family physician is not successful in obtaining the specialized care required for individuals with nervous and mental disorders.

Alter, J. Narrowing Our Medical Care Gap. Jericho, New York: Exposition Press, 1972.

The author maintains that psychosocial factors, as expressed in smoking, drinking, overeating, alcohol and drug intake, and interpersonal and intergroup frictions, contribute to morbidity and mortality. This brief, easy-to-read account is designed to show the inadequacy of current health insurance measures and to show that government funding of hospital construction, Medicare, and Medicaid have helped raise hospital utilization without improving health care. It is also noted that excessive specialization has fragmented health service and suggests training health providers in community settings rather than in hospitals.

The author concludes that we are spending enough now to buy two Kaiser-type subscriptions for each person in the country.

Ayres, J. "Accelerating Skyrocketing Health Care Cost," New England Journal of Medicine 296, 1977: 391-393.

Controls to price, supply and demand are being applied in statute by legislators, in regulations by bureaucrats, contracts by third party payors, and voluntarily by some organizations and individuals. As costs rise, so does the demand to close open-ended reimbursement, capping fees by fee schedules or salary or capitation, to the point that providers are reluctant to cater to segments of the population. The addition of deductibles and co-payment seeks to discourage demand or ration supply. The new health planning legislation (PL 93-641) with its consumer dominated boards is intended to regulate facilities and resources. It has been dubbed "passengers flying the airplane" legislation.

An emerging view is that with a closed-ended resource allocation system, priorities would be changed from heavy spending on complex tertiary care to spending for more accessible and available primary and secondary services. This would force consumers and providers to give up the "technological imperative," the "do everything" approach. Stated baldly, it would trade dollars for lives in order to save the most lives with fixed resources. Unanswered are criteria for making these decisions and who will make them.

Barth, P. "The Effort to Rehabilitate Workers' Compensation," American Journal of Public Health 66, 1976: 553-557.

The current system compensates only a small proportion of serious cases of disability arising from occupational diseases. The general public disinterest in these programs allows the parameters of change to be set by the involved interest groups. There is a growing effort to force change upon state programs by legislation. A uniform national law would eliminate the prevailing gross discrepancies across the states, as in the reform legislations proposed by Senator Williams (S. 2018). System redesign could induce the provision of safe and healthful work environments and the availability to disabled workers of medical and rehabilitation services. Private health insurance now provides substantial medical and hospital service coverage. Conceivably, Workers' Compensation could evolve a system whereby employers supplement all medical and rehabilitation costs not borne by private insurance or a national health scheme.

Binner, P., Halpern, J. and Potter, A. "Patients, Programs and Results in a Comprehensive Mental Health Center," Journal of Consulting and Clinical Psychology 41, 1973: 148-156.

Using a value output index, the authors found that "the best return for the program dollar invested can be realized by giving treatment of very low intensity to all patients regardless of their level of impairment." They argue for maximum possible use of inpatient care. In no case, however, did the analysis find less than a dollar's worth of value returned for each program dollar invested. This article provides a means of measuring therapeutic outcome according to the intensity of the treatment process, while also taking into account the degree of severity of the mental condition.

Bodenheimer, T. "The Hoax of National Health Insurance." American Journal of Public Health 62, 1972: 1324-1327.

This critical study of National Health Insurance suggests that it is designed to meet a health care crisis caused by financial instability, influential providers and payers of health care. The author sees the common element of all such plans as the transfer of money from working Americans to powerful payers and providers. He forecasts the evolution of tax-subsidized, monopolistic, health industry empires.

Burnell, G.M. "Financing Mental Health Care--An Appraisal of Various Models." Archives of General Psychiatry 25, 1971: 49-55.

The financing of psychiatric care is viewed as an important variable in determining the type of treatment, the duration of hospitalization, and the length of outpatient psychotherapy. Despite many clinical innovations, new legislation, and increased federal funding in the last decade, there is only scant research data on new methods of financing mental health care. Current economic models include: (1) fee-for-service plans, (2) commercial and governmental insurance plans, (3) prepayment plans, and (4) public subsidy plans. The advantages and disadvantages of each economic model are analyzed. The author concludes that there is a close relationship between economic models and the types of delivery of mental health services and that there is an urgent need for systematic studies of cost, utilization, and clinical effectiveness within the framework of each economic system.

Cailliet, R. "Rehabilitation Medicine: Its Future in National Health Programs." Archives of Physical Medicine and Rehabilitation 56, 1975: 97-100.

The medical and psychosocial benefits of rehabilitation are well documented in this presidential address to the American Congress of Rehabilitation Medicine. It points out that the average practitioner loses interest in the third phase of health care, the residual disability, once acute diagnosis and treatment are passed. The failure to define rehabilitation in the Medicare Law is noted.

California. S.B. 110, California Budget Act for 1977-78.

In General Fund Item 260, Department of Rehabilitation, a 4.4% general fund increase to $11.34 million is projected. In 1976-77 the Department of Rehabilitation gave priority to the severely and moderately disabled plus those with substantial vocational handicap derived from mild disabilities. For 1977-78 priority would: assure services first to persons with severe functional limitations; expand services to the industrially injured; and increase counselor services to the developmentally disabled. During 1975-76 the severely handicapped comprised 35% of disabled persons rehabilitated. The projection for 1977-78 is that mental disabilities will comprise 39% of new plans and 38% of rehabilitations.

The legislative analyst's report notes a projected significant increase in reimbursements through a new program serving industrially injured workers. Prior cost-benefit analyses have shown effective returns in relatively brief times by savings in Welfare, Medi-Cal and Social Security plus increased tax revenues. However, the estimated time to gain return on investment has been rising from 2.8 to 3.7 to 4.6 years in 1973-74, 74-75 and 75-76 respectively. The Rehabilitation Act of 1973, by placing national emphasis on service to the severely disabled, will result in a significant reduction in the number who can be rehabilitated annually. By 1975-76 the ratio of non-rehabilitated to rehabilitated had increased to 89% (from 54.7% and projected at 92.3% for 1976-77). California Statutes of 1974 (AB 760) require that vocational rehabilitation services be a regular benefit under the Workers' Compensation program. It is not clear however whether the Department can compete with private agencies. Further legislative review is requested of current policy trends toward funding prevocational and independent living skills programs.

California. Welfare and Institutions Code. ss 10651, 10654, 19000, 19018, 19450, 19942, 19946 (West, 1972).

In Division 9, Public Social Services; Chapter 2.5, Rehabilitation and Employment Coordination:

Section 10651 seeks to combat poverty and reduce dependency by placing special emphasis on the rehabilitation of public assistance recipients.

Section 10651 calls for joint action by the Departments of Health and Rehabilitaiton in the selection of recipients who would qualify and benefit from rehabilitation services.

Section 10654 assigns to the Division of Vocational Education of the State Department of Education, primary responsibility for the education and training of public assistance recipients.

In Division 10, State Department of Rehabilitation; Chapter 1, Powers and Duties:

Section 19000 empowers the Department to promote the effective coordination of all public and private agencies serving the handicapped, and to maximize self-sufficiency and gainful employment for the handicapped.

Section 19018 defines "handicapped individual" as having a physical or mental disability which constitutes a substantial handicap to employment but for which vocational rehabilitation services are expected to result in gainful employment.

Section 19450 enables the Department to establish residential rehabilitation facilities for those mentally retarded who require a protected living environment.

Section 19942 provides for contracts between the Department and the Office of Alcohol Program Management for county funding of vocational rehabilitation services and will utilize (sec. 19946) private alcoholism programs prior to developing new county operated programs.

Canada, Department of National Health and Welfare. Health and Welfare Services in Canada, Research and Statistics Directorate, 1971.

An overview of Canada's health and associated welfare resources is presented. Under the Hospital Insurance and Diagnostic Services Act of 1957 the federal government cost-shared specified services. With the inclusion of Quebec in 1961 all provinces were involved. The Medical Care Insurance Act was not adopted until 1968 on a cost-share basis with the provinces, all of which had joined by 1971. The concepts of comprehensive universal and portable benefits on a non-profit basis were established. The details varied from province to province. By 1970 Canada was expending 10.7% of its GNP on Health and Social Welfare.

A federal-provincial rehabilitation program began in 1952, consolidated under the VR of Disabled Persons Act in 1961. There is an equal sharing between federal and provincial governments. Approved services may be supplied by a provincial government or on contract. Data shows that the program has been cost effective, and has complemented Workmen's Compensation and health services, but has remained distinct.

Cohen, A. and Margolis B. "Initial Psychological Research Related to the Occupational Safety and Health Act of 1970." American Psychologist 28, 1973: 600-606.

PL 91-596 applies to all industrial establishments engaged in interstate commerce and seeks to promote safe and healthful working conditions. Research provisions of the act acknowledge psychological, behavioral and motivational factors in worker safety and health. Focus on job stresses and exposure limits to noise and toxic substances could ascertain the potential for illness, disease or loss of functional capacity. Behavioral methods are seen as useful in detecting occupational hazards, tolerance to job stress and in reshaping faulty or unsafe work habits.

Commission on Accreditation of Rehabilitation Facilities. Standards Manual for Rehabilitation Facilities. Chicago, Illinois: 1973.

This 127-page document is the revision of the original 1965 manual. It is comprised of five major parts: (1) an introductory section, including a glossary and criteria of eligibility for accreditation; (2) the standards, organized under nine basic areas; (3) an interpretation section for each major standard; (4) a checklist for preliminary self-survey; and (5) the Commission's policies and procedures for conducting surveys.

Committee for Economic Development (CED), Research and Policy Committee. Building a National Health Care System. New York: 1973.

The authors find that nearly half the increase in expenditure for personal health care since 1950 is due to price, rather than to greater utilization or new techniques. A functional as well as geographic maldistribution of manpower and resources and national inadequacy in primary care are noted. Prospective rate setting and national policy in the support of health manpower training is advocated. The authors provide data and analysis on manpower, costs, hospital use, mental health, and so on. The objective is an integrated, prepaid comprehensive health care system developed on a phase-in approach. A carefully developed study report and pertinent reference.

Conley, R. The Economics of Mental Retardation. Baltimore: Johns Hopkins Press, 1973.

This book is based on a 1971 study, commissioned by the President's Committee on Mental Retardation, which estimates that the social

well-being of the United States was reduced by an annual rate of $7 billion due to mental retardation. Of this amount, $4.8 billion was caused by the loss of productivity by underemployment, and $2.2 billion by "excess costs" of programs.

Correia, E. National Health Insurance, Welfare Reform and the Disabled: Issues in Program Reform. Office of the Assistant Secretary for Planning and Evaluation, Department of Health, Education and Welfare, August 1976.

A section on Rehabilitation and NHI notes that the major proposals do not specifically address rehabilitation problems. The distinctions between grant and reimbursement financing are highlighted. The former involves a fixed budget to be allocated among clients by the service agency, in contrast to the individual entitlement for reimbursement of covered services in an insurance plan. The constraints upon choice of provider and services that will be paid for are largely absent. Moreover, insurance carries an automatic entitlement to services. A tradeoff, from VR management perspective, is that the grantee agency has flexibility in the allocation of expenditures whereas under insurance the decision is largely taken out of the control of the third party and is a matter between user and provider. The insurance mechanism is not well suited to extended rehabilitation, nor to making service choices on the basis of worth or efficiency.

Cummings, N. "Medicare Reform Testimony to the U.S. Senate." The Clinical Psychologist 30, 1976: 21-23.

The psychological aspects of disability, injury, illness, chronic disease, death and dying--quite apart from mental disorder--are widely recognized among practitioners. In fact, 68% of the doctor visits to the Kaiser Health Plan, made by 36% of its 1.3 million members were for complaints for which no organic cause could be found. The availability of mental health services have been shown to dramatically reduce the extent of subsequent use of surgical, in-hospital and diagnostic laboratory services. By translating personal problems into physical symptoms, patients receive a great deal of laboratory, prescription, and return doctor visit attention. Thus the cost of psychotherapy is offset by substantial reduction in other health plan costs, health plan utilization stabilizes, and subscribers are restored to a more optimal level of functioning.

Davis, K. "National Health Insurance: Benefits, Costs and Consequences." In: Studies in Social Economics. Washington, D.C.: The Brookings Institution, 1975.

Present diverse public health programs lack a unifying policy. The growth of the private health insurance industry to $32 billion in 1975 has been closely linked to the work place, with resultant major gaps in coverage. Health services are now a $100 billion industry. It follows then that to be accepted and functional, a NHI plan must be equitably financed, easy to understand and administer, and acceptable to the providers. Revamping the payment system might enable reorganization of health delivery but these are not primary NHI goals.

An analysis of the implications of the major NHI proposals placed before Congress suggests that those neither poor enough to qualify for governmental assistance nor with sufficient assets to afford the full costs may be most adversely affected. Major cost implications are specified, such as the inflationary potential of covering the entire costs of short hospital stays, the UCR fee practice, and excessive use of advanced technology under catastrophic coverage. Any NHI plan that does not involve the private companies is likely to result in substantial displacement effects because of their current substantial role. There is a great degree of uniformity in goals of the bills before Congress, and they appear to differ little in real costs. Rather, they differ markedly in methods of financing, administration, and reimbursement of providers.

Donabedian, A. "Issues in National Health Insurance." American Journal of Public Health 66, 1976: 345-350.

Imposing financial disincentives to utilization reduces protection for those who need it the most. They are also likely to inhibit prevention, early detection and timely care. Is NHI to be a scheme to protect against the costs of illness and/or a force to reshape the medical care system? Health insurance has three initial effects:

1) lowers out-of-pocket price the consumer pays for covered services;

2) by so doing it improves ability to pay for added non covered services;

3) it facilitates the flow of revenue to the provider in fee for service.

These effects combine to alter the behavior of clients and providers. The result is major change in volume, content and distribution of services utilized as follows:

1) more covered services are used, generating added complementary services (greater volume);

2) services are enriched in technological content and amenities;

3) in this increase there is a decided tendency to favor services that are more fully covered by insurance and to substitute these for non-covered services;

4) use of less urgent services enhanced, the more urgent likely sought irrespective of insurance;

5) if coverage is available, preventive services more likely enhanced than therapeutic services;

6) use of services by poor and previously uninsured more likely enhanced.

The consequence is price rise because of increased demand upon limited capacity and demand for service richer in content, in effect a process which feeds upon itself. How to finance the program involves some deeply entrenched and opposing social values.

Certain costs cannot be circumvented. Hence, cost control must focus on those expenditures which yield less than proportionate benefits. In prepaid group practice ambulatory care is associated with reduction of hospital use due to confluence of broader range of benefits, different method of physician payment and internal professional and administrative controls. Otherwise, the provision of outpatient diagnostic services and office visits, home care and nursing care leads to greater consumption without commensurate reduction in hospital use. Overall costs increase. Access to non-hospital services becomes the occasion for recommending hospital care.

Health insurance involves a concept of equity, the transfer of funds from one group to another--income redistribution. Community rating would do this also but it cannot survive in a free competitive market because such plans are underbid and driven out by experience rated competition. A redistributive form of equity can only be achieved by governmental action. Medicaid transfers resources from well to do to the poor.

NHI by generating new purchasing power encourages physicians to move into areas of higher per capita income where prevailing fees are higher. Simple availability of benefits will not attract doctors to underserved areas.

To assure quality, improve productivity, eliminate unnecessary care and control prices there must be system structural changes in the organization and remuneration for delivery of care. There must also be a system for monitoring profession and organizational performance.

Dorken, H. "CHAMPUS Ten State Claim Experience for Mental Disorder: Fiscal Year 1975." American Psychologist 32(9), September 1977: 697-710.

Substantial data on utilization of mental health services is reported by state, by provider, by procedure, by diagnosis and for inpatient and outpatient visits. Fees are reported for three fiscal years. Utilization of mental health services has remained stable at just under 2% of those eligible from 1973-1975. Individual psychotherapy is the predominant procedure, and accounts for 81% of all outpatient visits to all providers. The average fee paid to psychologists and psychiatrists for this procedure was $36.04 and $37.59, respectively. The coverage for dependents of active duty personnel and retired military personnel and their dependents, while extensive, is on a second dollar basis. An eligible beneficiary with health insurance through employment must use those benefits first. The coordination of benefits principle is clearly established in this program.

_____. "Psychologist, Is There a Foundation in Your Future?" Journal of Community Psychology 2, 1974: 99-103.

The recent formation and spread of the Foundation for Medical Care (FMC) movement is described. Once called the county medical society's answer to Kaiser, and pioneered in Stockton, California, the FMC concept has spread to over 30 counties in the State and to a growing number of areas in other states. They are recognized in the Health Maintenance Organization and Development Act, PL 93-222, as Individual Practice Associations. As a federation of individual fee service practitioners, they are able to contract for health care plans and to do so on an at-risk basis. That is, they assume total health care responsibility for the contracted benefit package on a prepaid basis. All claims and practices are internally subject to peer review.

Reimbursement is on a fee-service according to an annually determined fee schedule. Practicing psychologists are now members of several Foundations.

_____, et al. The Professional Psychologist Today: New Developments in Law, Health Insurance and Health Practice. San Francisco: Jossey Bass, 1976.

While directed primarily to psychologists in health practice, this book summarizes major recent health legislation at both federal and state levels; reviews the various types of health insurance and the literature on the utilization of mental health services. It also describes some aspects of legislative advocacy and emerging issues among health professions.

Dwight, J. "Bringing Better Management to Medicaid." Social and Rehabilitation Record 2, May 1975: 24-26.

The program established for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI), most aged, blind and disabled individuals, serves about 25 million people at an annual cost of $13.5 billion. Additionally, 29 states provide assistance to the medically needy, some 7 million persons. Ineligibility among the latter is thought to run as high as 20%. Introduction of a quality control system is described.

Education for All Handicapped Children Act of 1975. Public Law 94-142, November 29, 1975. 89 Stat. 773, 20 USC s1401.

The law seeks to provide effective special education, and early identification and assessment of handicapping conditions for the 8 million handicapped children in the U.S. Developmental, corrective and supportive services include psychological services; medical services are for diagnosis and evaluation only.

An individualized education program is required for each handicapped child at the beginning of each school year, including those in private schools, and study of the effectiveness of these programs.

Disorders in basic psychological processes include perceptional handicap, brain injury, dyslexia and developmental aphasia, but do not include learning problems primarily the result of mental retardation or emotional disturbance.

Enthoven, A. "Can We Control the Cost of Health Care?" The Stanford Magazine Fall/Winter 1976: 14-19.

By 1973, at least 190 million persons had private insurance, Medicare, Medicaid or some form of government assistance. Costs in an absolute and relative sense have been rising rapidly in recent years due to cost-increasing incentives:

1) the medical care system can legitimately absorb every dollar society will give it;

2) the doctor-patient relationship rejects the intrusion of cost considerations;

3) physician income per hour for hospital work is three times that for office work;

4) cost overruns and inflation have been the universal experience of cost reimbursement systems in all fields; and,

5) the third party effect of delay for the consumer who, having paid his premiums, has every incentive to collect benefits that might help him.

Physicians have considerable discretionary power to control the prices they charge and the amount of services they supply. The more doctoring, the higher the costs. Many studies have shown that per capita hospitalization and surgery is much higher under fee for service than prepaid per capita financing. Reducing the immediate burden of medical care results in a shift from co-payment to taxes and premiums. There is no evidence that cost-sharing discourages unnecessary, as opposed to necessary, care. The consumer also, is not in a position to shop around and compare values. One way or another costs will be controlled. They are too high not to be. A decentralized market competition economy has been effective in the production and distribution of most goods and services. It could apply to health care by improving the ability of consumers to make an informed choice among genuine alternative medical care delivery systems. Some of the NHI bills look like a charter for a monopoly run by and for doctors and hospitals.

Follette, W., and Cummings, N. "Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting." Medical Care 5, 1967: 25-35.

Classic study showing that psychotherapy groups were high utilizers of medical facilities. For the "one-interview" and "brief psychotherapy" groups there was subsequent significant decline in overall utilization. For the long-term psychotherapy group, inpatient utilization declined significantly, to a level comparable to the general health plan population.

Follman, J.R., Jr. Insurance Coverage for Mental Illness. New York: American Management Association, 1970.

A quick overview of the problems of mental illness, its treatment, and financing of care is provided. Insurance coverage and other types of protection are described, and some actuarial experience is cited. Some of the findings include the facts that:

- 50% of patients treated by general practitioners have emotional components;
- 43% of Army disability discharges during World War II were for neuropsychiatric reasons;
- there are 5 million mentally retarded persons in the United States;
- emotional illness causes more absenteeism from work than any other illness except the common cold, costing American business $10 billion yearly;
- about 80 to 90% of industrial accidents originate in some type of mental or personality problem--these accidents kill 15,000 and disable 2 million each year at an estimated cost of $3 billion;
- a total of 1.7 million alcoholics are employed in American industry, losing, on the average, 22 days of work a year because of alcoholism or its physical effects.

Garfield, S., et al. "Evaluation of an Ambulatory Medical Care Delivery System." New England Journal of Medicine 294, 1976: 426-431.

Though health insurance plans seek to eliminate the fee-service financial barriers to access for health care, they have a counter effect which is to increase demand, inflate cost, and contribute to physician maldistribution. The great surge of demand following introduction of Medicare and Medicaid illustrates this well.

The Kaiser plan introduced two basic changes. First, rather than the exclusive physician entrance mode, the method of access is through a comprehensive health evaluation service by paraprofessionals and nurse practitioners with minimum physician supervision. This triage separates the clients into four groups: the well, 57%; the worried well, 11.5%; the asymptomatic sick, 4%; and the sick, 27.5%. The "uncertainty" demand of the first three groups, 72.5%, is handled by a health care service for the first two, a preventive maintenance service with monitoring and follow-up for the third, and physician sick care service for those with acute or chronic illness. Thus, entry and follow-up care were uncoupled into two separate services, optimizing each.

This system meets the sick care needs of the few and the health care needs of the many. The capacity of this system for new and return visits in terms of the physician is a twenty-fold increase over the traditional medical system.

Goldberg, I., Krantz, G., and Locke, B. "Effect of a Short-Term Out-Patient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program." Medical Care, 8, 1970: 419-428.

This report duplicates studies by Cummings and Follette and indicates that medical utilization declines as much as 30% following mental health consultation. The year after referral, study patients showed a marked reduction in utilization, primarily in the diagnostic, X-ray, and laboratory studies. Results, at the Group Health Association, District of Columbia, support the thesis that inclusion of mental health services leads to more appropriate and efficient overall utilization.

Halliday, W.R. "Rehabilitation of Injured Workmen with Psycho-Social Handicaps." In: Leedy, J.J. (Ed.). Compensation in Psychiatric Disability and Rehabilitation. Springfield, Ill.: Charles C. Thomas, 1971, 338-348.

Data on medical care under Workmen's Compensation in Washington state is presented. Although one in four workers is treated annually for as much as 60 days, 6,000 have severe, long-term disabilities. Another 3,000 to 4,000 have apparently minor injuries but prolonged complaints. These so-called problem cases are potential victims of "the disability process." A program of "medico-vocational" rehabilitation is described. Rehabilitation of eleven cases to gainful employment obviated the necessity of pensions that would have required pension reserves of $583,306.

Hannings, R., Ash, P. and Simick, D. Forensic Psychology in Disability Adjudication: A Decade of Experience. HEW Publication No. 72-10284. Washington, D.C.: U.S. Department of Health, Education, and Welfare, Social Security Administration, 1972.

The history of disability determination under Social Security and the involvement of psychologists as vocational experts is outlined. Under Social Security, disability means "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment. . . ." Following judicial establishment of the Kerner criteria in 1960, not only must the claimant be able to work, but work must be available. In effect, an employability rather than a disability test is required. Rehabilitation potential is not the issue, but rather the transferability of skills--the transliteration of medically determined impairment into functional terminology and residual capacities, and an appreciation of concomitant psychosocial overlays such as a motivation to remain disabled. Hearings are concerned with availability of work the claimant is able to do. Effective performance as a vocational expert requires an intimate knowledge of the job market and skills required by job. From a legal standpoint, vocational expert testimony is considered the best type of vocational evidence obtainable. Experts are appearing in a higher percentage of hearings on disability claims: 2.9% in 1963 and 24.5% by 1971.

Health Insurance Institute. Source Book of Health Insurance Data 1974-75. New York: 1975.

The Health Insurance Institute represents 327 member companies that issue about 85% of the health insurance written by insurance companies in the United States. The history of health insurance and growing involvement in HMOs is traced. Data is reported from 1940-73 on: hospital expense--82 million insured; surgical expense--169 million insured; regular medical expense--152 million insured; and major medical expense--82 million insured. Ratio of primary insured persons to dependents ranged from 1.51 to 1.73. Total U.S. health insurance payments in 1972 were $10.6 billion and $10.4 billion by insurance companies and Blue Cross-Blue Shield respectively. Americans spend 3.19% of disposable personal income on health insurance premiums. The Sourcebook contains a glossary of common insurance terms.

_____. Source Book of Health Insurance Data, 1976-77. New York: 1977.

This booklet provides a summary tabulation of many key health insurance statistics. There continues to be substantial growth in the dollar volume (premiums and benefit payments) whereas the number of persons under 65 with health insurance grew but a percent or two from 1974-75. For the five years from 1970-75, 11.2% more persons were covered for hospital expense (165 million) and 20% more had major medical coverage (90 million). In 1975, the average length of hospital stay was 7.7 days at a per diem cost of $151.

The HMO concept stresses ambulatory and preventive care. By 1976 the number of operational HMO's had increased to 197 with a 6 million enrollment. Proportionally, major medical expense insurance has been more rapid in its growth than any other form of health insurance and by 1976, 81% of those so covered had maximum benefits exceeding $100,000, the large majority of these over a quarter million.

Coverage for mental disorder is typically more restricted. Of persons insured 96% had mental benefits but the usual limits were $500 per year per outpatient, $10,000 per lifetime and a 50% co-insurance rate.

In 1975, of all those enrolled in the compulsory part A hospitalization insurance of Medicare, 97.4% were also enrolled in the supplementary, voluntary part B. During 1975 Americans spent the equivalent of 3.6% of disposable personal income for health insurance premiums. About 1 in 7 persons were admitted to community hospitals this year, these hospitals handling 92% of all admissions. The average number of physician visits was 5.1 per person and 5.2 workloss days.

Heck, E. "Professional Psychology and Public Programs: A Critique." Professional Psychology 7, 1976: 420-427.

Public mental health services are viewed as islands of program oriented, subsidized service in a sea of individually arranged, fee for service contracts. The program character is susceptible to political pressures and those of the funding agency. These organizations are fraught with conflict of interest. They cannot impartially regulate the services they provide, nor can they be expected to efficiently deliver services they fund in the absence of competition. Public mental health and similar programs could be profoundly influenced by NHI, which is likely to shift the focus of funding to individual service consumers and away from arbitrarily defined service programs. Recent mandatory inclusion of mental health benefits in group health insurance policies by Massachusetts and a dozen other states, may anticipate

changes to come. The services provided to individuals and funded by third party payors, will be defined as to content, duration, outcome, cost and qualifications of providers by regulatory agencies traditionally uninvolved with, and unsympathetic toward, public mental health programs. Their influence will prevail because they will control the funding power to implement change.

Hewlett-Packard Company v. Barnes, 425 F. Supp 1294 (1977).

Several major corporations and unions took action to prevent enforcement of the State Health Care Service Act by permanent injunction, claiming that State regulation of employee welfare benefit plans--including "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability . . ."--had been pre-empted by the Employee Retirement Income Security Act (ERISA) of 1974. The U.S. District Court of Northern California found for the plaintiffs and granted summary judgment. Congressional intent is clearly reflected in a statement of the Chair, Subcommittee on Labor, House Labor and Education Committee, ". . . I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefits plans . . . eliminating the threat of conflicting and inconsistent State and local regulation."

Insurance Information Institute. Insurance Facts 1976. New York City: 1976.

Information on a broad range of insurance is presented. Countrywide, health insurance benefits paid in 1973 by insurance companies totalled nearly $11.9 billion and by Blue Cross, Blue Shield and other hospital-medical plans some $11.7 billion. Workers' Compensation insurance--designed to pay for the cost of effective medical care, rehabilitation, and lost wages for injured employees, and death benefits for dependents of persons killed in work-connected accidents--has broadened considerably in recent years due to changes in state laws. Since 1969 its premium volume has almost doubled, by 1975 reaching a $6.1 billion level, 28% higher than the $4.76 billion level of 1973.

LaVor, M. & Duncan, J. "Vocational Rehabilitation--the New Law and its Implications for the Future." Journal of Rehabilitation 42, 1976: 20-28, 39.

The Rehabilitation Extension Act of 1976, PL 94-230, extended the program for two years, with very moderate growth of $20 million annually from the 1976 appropriation of $720 million. The intent was to enable states to plan ahead and allow additional time to evaluate the changes of the 1973 Act.

Though priority is to be given to the severely handicapped, and RSA has set "objectives," the term lacks adequate definition. In formulating the 1973 Act Congress sought to redirect the program from the increasing emphasis on "behavioral disorders" to encourage service to those with severe physical or mental handicaps. The House had sought to add a new Title III, a grant program to serve individuals who did not have the potential to return to work, but who could benefit from services in order to live independently. The Senate earmarked 15% of the authorization for similar purpose. The compromise was vetoed because it would divert the program from its basic vocational objectives into activities that have no vocational element and are essentially medical in character. The Administration clearly sought to retain the focus on restoration to employment since a similar bill was again vetoed 5 months later. The final compromise bill, PL 93-112, deleted the controversial title and the categorical nature of the program was preserved along with the requirement of a designated sole state agency to administer it.

The very significant "bill of rights" for the handicapped section of the 1973 Act was just implemented in regulations in the spring of 1977. One of the major problems raised by the Act is the wisdom of priority on serving the severely handicapped, if they are a class for whom a vocational goal is not possible. The need for additional research monies was apparent, though the increase to $24 million was only 75% of the funds available 4 years ago.

Leonard Z. "Utilization Control in Medicaid." Social and Rehabilitation Record 2, 1974: 29-31.

The 1972 Social Security Amendments included section 1903(g), establishing control over utilization of institutional services. Physicians are required to certify at the time of admission that hospital, SNF, MH or ICF services are necessary on an inpatient basis and recertify after 60 days. The plan of care for each patient must be developed and periodically reviewed by a physician. This includes all items of care and services ordered by a physician in conjunction with other personnel which contribute to the improvement or maintenance of the patient's physical, psychological or social condition.

Without operative state utilization controls, federal financial participation could be decreased by a third. The first state adherence review began November 1973.

An Institution for Mental Disease (IMD) is additionally classified as a hospital, SMR, ICF or combination. Services under Medicaid in IMD's are limited to persons over 65 and to hospital services for those under 21.

Lipson, M., "Federal and State Law Developments Which Will Shape and Limit Present and Future Rehabilitation Programs." Archives of Physical Medicine and Rehabilitation 57, 1976: 547.

The 1975 Medicaid regulations (PL 92-603) have defined routine hospital costs above the 80th percentile as being excessive and inefficient and some payments have been withheld. Most states have decreased the number of eligible patients and medical payment amounts in Medicaid. As a result, the total income and quality of rehabilitation programs will be reduced. Strong new federal state agencies (PL 93-641) are likely to ration rehabilitation services in institutions and through home care.

Margolis, R. "National Health Insurance--The Dream Whose Time Has Come?" New York Times Magazine January 9, 1977: 12-13, 32-33, 36, 38, 40-43.

The US is the world's only industrialized nation without a universal health insurance program, yet no country spends as much per capita on health care as we do. The price rose to $133 billion in 1976, making health care the third largest industry, behind agriculture and construction. The introduction of Medicare and Medicaid saw a tripling of annual per capita expenditures and the introduction of fraud. Close to half the people who file pleas for bankruptcy each year do so because of medical debts. M & M's payment of reasonable and customary charges to hospitals and doctors invites inflation.

Long-Ribicoff, the catastrophic coverage plan, would continue the Medicare blank check. The Kennedy-Corman Health Security Act would tie the health budget to the general economy and curtail the rates and fees paid to doctors and hospitals. The Nixon CHIP plan has impressed many as a workable compromise between two extremes. Private coverage is hedged with co-insurance and other limits. The HIAA National Health Care Act has the distinction of being the only plan that permits employers to dismiss it, as

it is strictly voluntary. Health Security represents a major shift of power and responsibility away from state governments and private insurance toward DHEW and federal bureaucracy. Medicare does not suggest that DHEW can run a program more efficiently. There would also be consequences to dismantling the insurance industry with a half million employees. CHIP nearly passed ways and means in 1974.

Mathews v. Eldridge, 424 US 319, 47 LEd2d 18, 96 S. Ct. 893 (1976).

Regarding the joint administration of disability insurance by state and federal agencies, footnote 13 summarizes that, "In all but six States the state vocational rehabilitation agency charged with administering the state plan under the Vocational Rehabilitation Act. . . . acts as the state agency for purposes of the disability insurance program. . . . This assignment of responsibility was intended to encourage rehabilitation contacts for disabled workers. . . ."

Mitchell B. and Schwartz, W. The Financing of National Health Insurance. Santa Monica, California: The Rand Corporation. May 1976. R-1711-HEW.

The distribution of costs among income groups is viewed as a central issue in the NHI debate. The redistribution of income created by health insurance financing under four prototypical proposals is analyzed, finding that adoption of a subsidized premium approach could minimize the added burden upon middle and upper income taxpayers. The discussion and footnotes cover the pros and cons of public versus private administration.

"National Health Insurance: Which Way to Go?" Consumer Reports 40, 1975: 118-124.

Health expenditures now claim 7.8% of the GNP. The marriage of public funding and private administration, wide variance in health under welfare, and lack of incentive to preventive care are cited as major problems. The major national and health insurance proposals are analyzed, noting that the United States is the only major industrial nation without a comprehensive national plan. "The significant difference among the plans is not the total cost, but who pays it and how." The article analyzes the five main national health insurance proposals of the 93rd Congress in terms of how they meet consumer goals;

describes these goals; compares costs; and offers certain recommendations. A concise, salient, and readily understood review of the issues.

Pollard, O. "The State-Federal Program: A Point of View." Journal of Rehabilitation 42, 1976: 21 & 36.

The trend to lump all human services together into large unwieldy umbrella agencies under the notion that categorical approaches are obsolescent is deplored.

Passage of the Rehabilitation Act of 1973 raised the expectations of people while at the same time there was a leveling and diminishing of funds. Consequently, authorized services are not provided. Some handicapped have been misled into believing that there was an expansion of the legal base for serving people without vocational rehabilitation potential.

Rehabilitation Act of 1973. Public Law 93-112, September 26, 1973. 87 Stat. 355, 29 USC s701.

The Rehabilitation Act of 1973 placed special emphasis on services to those with the most severe handicaps, and called for coordination of all programs within DHEW with respect to the handicapped. Among authorized programs was: "(5) develop new and innovative methods of applying the most advanced medical technology . . . psychological and social knowledge to solve rehabilitation problems. . . ." Diagnostic studies and restorative services for physical and/or mental disability up to 18 months were included, with the federal share at 80%, not to exceed 90% in certain cases. Severe handicap explicitly included mental retardation and mental illness. Rehabilitation services are to include medical, psychological, social and vocational services except that the medical and related health services are to be under direction of properly licensed personnel. Rehabilitation services are to be assured job disabled federal employees and public safety (fire, police) officers. Training, research and evaluation are included. Clearly, mental health problems which would be an employment/community living handicap can be embraced within rehabilitation services. While providing for coordination with public rehabilitation facilities/services there does not appear to be any benefit coordination requirement with extant health insurance.

Rehabilitation Act Amendments of 1974. Public Law 93-516, Dec. 7, 1974. 88 Stat. 1617, 29 USC s701.

In the Amendments, the Rehabilitation Services Administration was transferred to the Office of the Secretary of DHEW. "Handicapped individual" was defined as one having physical or mental impairment which substantially limits one or more major life activities; individual written rehabilitation programs were called for. The blind vending stand program was reviewed and support provided. A White House Conference on Handicapped Individuals was authorized.

Reynolds, James A. "Carter's Health Expert Fills in the Blanks: Special Report." Medical Economics October 18, 1976: 31, 35, 39-40, 45.

This article presents an interview with Dr. Peter Bourne, one of Jimmy Carter's health policy advisors. In discussing the phase-out of Medicaid Dr. Bourne comments, "Eventually, comprehensive coverage will absorb all of the existing health care programs." To do away with current runaway cost increases, funding would have to be based on predetermined costs: that is, cost levels for institutions and providers agreed upon in advance. In effect, UCR would be replaced by fee schedules.

Roemer, M. & Axelrod, S. "A National Health Service and Social Security: Commentary." American Journal of Public Health 67, 1977: 462-465.

The development and financing of universal and comprehensive health services in free market economies is described, noting that in many nations there are combinations of insurance and general revenue financing. There are often different patterns of delivery for hospital and ambulatory services in the same system. Thus, in Great Britain hospital care is delivered through organized arrangements, and in Germany by organized staffs of salaried doctors. Ambulatory care is still predominantly individualistic in Britain and by private doctors in Germany.

Only the socialist nations have so far developed predominantly organized ambulatory health services from general revenue financing. The United States has applied this system only to certain economically depressed populations, such as American Indians or impoverished city dwellers. In capitalistic countries

the use of general revenue as the initial basis of financing health care has been applied only to limited categorical populations. The serious hazard of the general revenue approach is its great political vulnerability to major reductions in funding.

Only when health care becomes firmly established as a right that cannot be reduced or eliminated can support be shifted to general revenue.

In industrialized capitalistic countries everywhere the initial strategy for broad population coverage has been social insurance or social security financing. By paying one's way one earns an entitlement to benefits. Then because these funds have a separate status, they have stability.

Health insurance tends to fortify private practice in the beginning but in time pressures mount for more organized and economical delivery patterns. In Britain the majority of previously solo private general practitioners are now in small groups and about 20% are in government health centers. Canada and other countries are all establishing health centers within the framework of their health insurance systems.

Scitovsky A. and McCall, N. "Coinsurance and the Demand for Physician Services: Four Years Later." Social Security Bulletin. May 1977: 19-27.

In 1967 a 25% across the board coinsurance was imposed upon the Group Health Plan offered by Stanford University to its employees. While hospital visits and services to children changed little, the per capita number of all physician services declined 24% in 1968. Moreover, this reduction was still evident four years later. What also occurred was a sharp drop in the number of non-professional subscribers by 1972, declining from 23% of all subscribers in 1966 and 1968 to just under 16% in 1972. Thus, the character of subscribers shifted towards the higher educated and presumably better paid.

To the stabilized GHP, member physician utilization rate of 3.6 visits a year should be added; 5 radiologist visits and 1.8 out of plan visits--more than half for not-covered psychiatric care--a total of 5.9. This was substantially higher than office visits reported in 1972 for Kaiser Northern California at 3.8 or total visits to HIP of Greater New York at 3.9.

Services and Payment in Medical Assistance Programs. 45 Code of Federal Regulations s 249.10 (1976).

Section 249.10(a) requires state medical assistance plans under Title XIX (Medicaid) to include at least the first five designated services to the categorically needy. If the state plan also includes the medically needy, then either these same first five services, or any seven of fourteen defined services must be provided. Item (b)(9) "Clinic services" includes rehabilitative services under physician direction. Item (b)(13), "Other diagnostic, screening, preventive and rehabilitative services" defines the latter as including "any medical remedial items or services prescribed for a patient by his physician or other licensed practitioner of the healing arts, within the scope of his practice as defined by state law, for the purpose of maximum reduction of physical or mental disability . . ."

Spencer W., "Statement on National Health Insurance Legislation on Behalf of the American Congress of Rehabilitation Medicine and American Academy of Physical Medicine and Rehabilitation to the Committee on Ways and Means, U.S. House of Representatives, April 26, 1974."

Coverage is advocated not only for the acute phase of health care, but also the rehabilitative phase, claiming that the latter can minimize the costs of long-term care. Concern is expressed for the failure of Medicare law to define rehabilitation, and the majority of his testimony is focused on the need to secure clear definition and delineation of responsibilities. The solution proposed is to rely on "the certification of a physician" to conceive of "rehabilitation services" as "a medically directed plan" to achieve specific outcomes which may include seven kinds of designated services plus such other "related services as are medically necessary."

US Department of Defense. Civilian Health and Medical Program of the Uniformed Services. How Other Health Plan Coverage Affects CHAMPUS Payments. Fact Sheet 7. 0-219-557. Washington, D.C.: US Government Printing Office, 1976.

Benefits of another health plan provided by law or employment must be used before CHAMPUS. Payments of the other plan may be used to help meet the 25% cost share and CHAMPUS deductible. CHAMPUS pays the remaining reasonable charges for authorized care.

There is a separate CHAMPUS program for the handicapped. It requires prior approval and is limited to dependents of active duty personnel for serious physical or mental handicap. There is a monthly cost share according to pay grade, following which CHAMPUS will pay up to $350 per month for authorized care including rehabilitation, training and special education. (see Fact Sheet 6, GPO 0-220-886, 1976).

US Department of Health, Education and Welfare. Proceedings of the Advisory Committee on National Health Insurance Issues, May 20-21, 1977. Washington, D.C.: 1977.

Secretary Califano introduced the Undersecretary of DHEW, Hale Champion, as Chairman in this first meeting of the Advisory Committee. The Committee was asked to examine NHI within the principles set forth by President Carter:

1) inclusion of preventive health services, particularly for children;

2) a universal, mandatory program with equality for all;

3) management efficiency;

4) quality assurance mechanisms;

5) citizen/consumer participation in administration and decision making; and,

6) the need for a phased-in plan and coordination with welfare reform.

Six key speakers were then heard outlining features of major NHI proposals, followed by Dr. Karen Davis who summarized the concensus and controversy:

1) coverage should be universal and mandatory, but whether a combination of private and public plans or entirely public was in disagreement;

2) encouragement of preventive and ambulatory services was widely agreed upon but the role of co-payment, if any, is highly controversial. None of the plans dealt with long-term care;

3) though there is concern for the impact of NHI on the federal budget, there is much disagreement over relative use of premium, payroll, excise or income taxes;

4) there is sharp dispute over the relative merits of public and private administration;

5) there is wide divergence on the nature of delivery systems, reimbursement strategies for providers, roles for new providers and alternatives in the organization of services. Probably this is the area of greatest disagreement.

Dr. Sidney Lee commented upon the Canadian experience where the Medical Care Act of 1966 followed the Hospital Insurance and Diagnostic Services Act of 1957. While administration was through the Provinces, benefits had to be portable, administration had to be public, all Provinces had to meet the federally determined comprehensive benefits, and each Province had to enroll not less than 95% of its population. Dr. Lee noted that hospitals are on prospective budgets and physicians paid according to a negotiated fee schedule. In his view, the waste in U.S. administration, public and private, was due to disability determination and collection of co-payments. He noted the actual decertification of out-moded and underutilized facilities in Canada and cited fee-for-service as a major contributor to increases in health care costs. Having a single payor, the provincial government, is an administrative saving.

_____. Towards a Comprehensive Health Policy for the 1970's: A White Paper. HEW 0-427-047. Washington, D.C.: US Government Printing Office, May 1971.

Problems are defined and solutions outlined. The administration's strategy is to modify the entire system of health, viewing the major problems as systemic. Considerable factual material is presented. Health occupations accounted for 3.6% of the workforce by 1966. A decline in the ratio of primary care physicians and disparity in geographic location of resources are noted. Health insurance is a financing market that often excludes or limits outpatient care and preventive services wherein ". . . . one party sets prices for services, a second receives them and a third pays for them, so that no one is concerned about rising costs." The strategy is to preserve and strengthen pluralistic private sector resources to avoid a single governmental system which is seen as a diseconomy and bureaucratic encumbrance.

US Department of Health, Education and Welfare, Health Resources Administration. The Supply of Health Manpower: 1970 Profiles and Projections to 1990. HRS 75-38. Washington, D.C.: December 1974.

Prepared in 1972-73, this 222-page health manpower reference provides "detailed occupational profiles" not only on physicians and medical specialists but also on optometrists, podiatrists, etc. Of 323,210 physicians active December 1970, 21,150 and 2,100 were in psychiatry and child psychiatry respectively, collectively 7.2% of the physician total. By the end of December 1972, their numbers were reported at 22,570 and 2,268 respectively, a total approaching 24,850. Optometrists numbered 18,400, podiatrists, 7,100. In such context, professional psychology is a substantial health manpower resource. Projected as a ratio of all psychiatrists to 10,000 of population, there were 1.14:10,000 in 1970.

The study was undertaken to provide baseline data for the development of optional strategies and policies in health manpower production. The four year medical school attrition rate is reported at 5.3%; 90% of physicians are involved in the direct care of patients.

An attempt was made to estimate also the supply of active allied health manpower. Clinical psychologists are listed under "other personnel" as are medical social workers. The estimated active personnel count in 1970 for these two professions was 13,000 and 25,200 respectively. States said to be requiring a license for these professions in 1971-72, number 46 and 9 respectively.

US Department of Health, Education and Welfare, Office of Human Development and Social and Rehabilitation Service. "Vocational Rehabilitation Programs, Implementing Provisions." Federal Register 40 (228), November 25, 1975: 54696-54731.

The provisions revise Chapter IV, Title 45 of the Code of Federal Regulations and amends Chapter XIII to effect the regulations for the Rehabilitation Act of 1973 and its amendments of 1974. Such services as extended evaluations and the 18 components of physical and mental restoration services are defined; the scope of an agency program (15 services) is delineated; and other regulatory guidance is included for implementation of the state Vocational Rehabilitation Program.

US Department of Health, Education and Welfare, Office of Human Development, Office for Handicapped Individuals. "A Summary of Selected Legislation Relating to the Handicapped 1975." In Programs for the Handicapped August 20, 1976.

The Developmentally Disabled Assistance and Bill of Rights Act, PL 94-103, broadens the term "developmental disability" to include dysletic children, and adults who also suffer from retardation, cerebral palsy, epilepsy or autism. All programs must have individualized habilitation plans for every client served.

The Education for All Handicapped Children Act of 1975, PL 94-142, made a sharply increased federal commitment to insure that all handicapped children receive full and appropriate educational services.

The Education Appropriations, PL 94-94, resulted from override of a presidential veto and contain a sharp increase in appropriations for state grants to assist in educating handicapped children.

US Department of Health, Education and Welfare, Office of Human Development, Rehabilitation Services Administration. Caseload Statistics, State Vocational Rehabilitation Agencies, 1976. RSA 77-25078. Washington, D.C.: 1977.

The downturn in caseload activity was pervasive. New referrals decreased 15%, the first such annual decrease in 17 years. Of all cases processed only 42% were accepted for services, the lowest rate since this measure was introduced in 1943. Of all cases closed only 63% were rehabilitated, the lowest proportion in 30 years in a program where a 75% level had been typical. The modest gain in rehabilitations of severely disabled of 6% and 2% from 1975-76 and 1974-75 was offset by losses in rehabilitations of non-severely disabled of 13% and 16% respectively. It costs more to serve the severe than the non-severely disabled. Many states have imposed a limitation on counselor staff which is likely to have a constricting influence on caseload size and raises questions about the ability of state agencies to meet the genuine needs of the non-severely disabled. The proportion of rehabilitated persons who received public assistance at some time during the VR process remained static at 19%. Cases not accepted for VR or extended evaluation comprised 40% of applicants.

In reflecting on trends it should be noted that two precursors to the Rehabilitation Act of 1973, PL 93-112, suffered presidential vetos. Also, conference report language governing eligibility for basic services intended to emphasize services for those with severe physical or mental disabilities--persons with social disadvantages or handicaps were not thereby eligible.

_____. Distribution of Source of Referral of Cases Closed by State Vocational Rehabilitation Agencies During Fiscal Year 1975. Information Memorandum RSA-IM-77-37. Washington, D.C.: February 11, 1977.

Clients referred by the Social Security Administration and public welfare agencies accounted for 51.7% of the total cases not accepted in 1975, 40.4% and 11.3% respectively. Persons referred by SSA, the largest single source of referral, comprised only 3.7% of the total rehabilitations. For the five years from 1971, referrals from private sources were likelier to be rehabilitated. It can be inferred that the motivation for rehabilitation of clients referred on a voluntary basis differs from those referred to satisfy mandatory requirements.

_____. Final Report on Characteristics of Clients Rehabilitated during Fiscal Year 1974. Information memo RSA-IM-76-87. Washington, D.C.: 1976.

The dominant disability for persons rehabilitated continued to be mental illness, accounting for 31% of all rehabilitations in 1974 (mental retardation 13%) an increase from 29% in 1972. The "other character, personality and behavior disorders" component leveled off at 14% during 1973 and 74. The proportion of clients receiving physical or mental restoration services declined from 47% in 1972 to 42%.

_____. Information Memorandum. RSA-IM-77-39. Washington, D.C.: 1977.

Nationally the rate of rehabilitations decreased steadily from 296 per 10,000 disabled in FY 1973 to 232 in 1976. Nationally the rehabilitation rate for severely disabled increased slightly to 94 per 10,000 in FY 1976. Among states, California ranked last at 37. The number of active cases served, 943 in FY 1976 per 10,000 disabled population, was lower than in the two prior years.

_____. Information Memorandum RSA-IM-77-71. Washington, D.C.: June 8, 1977.

A final report on rehabilitations for Fiscal Year 1976. The dominant major disabling condition for persons rehabilitated continues to be mental illness, 29%, with the "other character, personality and behavior disorder" component, though having decreased to 11%, remaining the single largest disability grouping. One of the more notable trends is the decline in the proportion of rehabilitated clients placed into jobs in the competitive labor market, down from 78% in 1974 to 74%. Correspondingly, homemaker placements have increased from 14% to 17%. Work status at closure reflects the impact of serving greater numbers of severely disabled persons.

Only 11% of cases were not accepted because the handicap was too severe; 14% because there was no disabling condition or vocational handicap. Two-thirds of the applicants refused to cooperate, refused services, or could not be located.

_____. Preliminary Report: Comparison of Characteristics of Severely and Non-Severely Disabled Clients Rehabilitated during Fiscal Year 1975. Memo by Andrew S. Adams, Commissioner. Washington, D.C.: October 22, 1975.

This preliminary report encompasses about 60% of all 1975 rehabilitated cases. One of every six of severely disabled had had special education and were more frequently referred from health related resources (24% versus 16%). One of every eleven had SSDI benefits as their primary source of support. More than one-fourth, 26%, of the severely disabled received public assistance payments at some time during the VR Process, 17% of the non-severe. Members of both groups were most often disabled as result of mental illness: 22.3% versus 35.3%; mental retardation 18.2% versus 8.8%; total mental disability 40.5% versus 44.1%. Only .8% of cases rehabilitated had been referred from Workmen's Compensation. At the time of referral only 12% of the severely disabled were employed in the competitive market, compared to 21% of non-severely disabled. By case closure substantial increase, 64% versus 85%, had been achieved.

At closure the proportion of clients with no earnings had been reduced for the severely disabled as against non-severely disabled from 85% to 21% versus 78% to 12%. At closure, those with earning averaged $95 versus $110 per week. There was only a 1 1/2 month difference in overall average time to rehabilitate: 18.3 versus 16.8 months. The average cost, however, was about

double for the severely disabled: $1141 versus $753. This has important implications for fund allocations.

Physical and mental restoration services were provided to 38% versus 41% of these two client groups. It should be noted that 17% of applicant closures were due to a finding of either no disability or no vocational handicap. The single most prevalent reason for closure however, among both referral and applicant closures, was client refusal of services, 31% and 26% respectively.

_____. Preliminary Report on Clients Rehabilitated during Fiscal Year 1976. Information Memorandum RSA-IM-77-21. Washington, D.C.: December 22, 1976

About one in four clients rehabilitated during fiscal year 1976 was a member of a minority racial group, the highest proportion ever recorded for minority group members. This was also the second consecutive year in which the average case cost to achieve rehabilitation exceeded $1000, it was $1047. The length of time required to achieve rehabilitation, from referral to closure, remained at about 20 months. The combined income of members of families of rehabilitated clients averaged $246 per month. The number of individuals receiving public assistance at referral has increased steadily since 1968, reaching a 19% higher level in 1974. In the five years from 1972 to 1976, clients who had never married comprised the bulk of the group, 43% to 46%. Only 18% of clients rehabilitated in 1976 were salaried in the competitive labor market or sheltered workshop upon referral. By closure this had quadrupled to 79%.

In terms of average weekly earnings the rise was from $17 at referral to $91 at closure, a gain of $74 per week, with 44% of those rehabilitated earning over $100 a week. From fiscal year 1972 through 1976 the number of cases closed progressively increased from .88 million to .98 to 1.0, and approaching 1.1 million in both 1975 and 1976. More than half (56%) these persons were not accepted in 1976 and of those accepted, 37% were not rehabilitated. Of the total cases closed, the 28% rehabilitated in 1976 represents a decline from the 30% level of 1975, and the 36% levels of 1974, 1973 and 1972.

_____. Preliminary Report: Comparison of Characteristics of Severely and Non-severely Disabled Clients Rehabilitated During Fiscal Years 1975-76. Information Memorandum RSA-IM-77-32.

The number of non-severely disabled clients rehabilitated in 76 declined 13% from the prior year, while the number of severe clients rehabilitated rose 6%, an overall 6% drop. Mental illness was the most common disabling condition, 25% among the severe, 32% among the non-severe, almost half the latter being "other character, personality and behavior disorders." Median costs for rehabilitation were less than half the average costs.

_____. State Vocational Rehabilitation Agency Program Data: Fiscal Year 1976. OHD 77-25053. Washington, D.C.: 1977.

Data covers July 1975 through June 1976. Of 1.96 million persons served, 303,000 were rehabilitated, of whom 123,000 were severely disabled, 6% more than the severely disabled rehabilitated in 1975. The number of clients continued to increase, but from 1974 the overall number rehabilitated had dropped 16%.

Nationally, the $898 million expenditures by category were: 8.2% administration; 34.9% counseling and placement; 52.1% services for individuals; 2.4% establishment of rehabilitation facilities; 7% services to groups; and .1% construction. Services for individuals totalled $467 million of which 16.2% was for diagnostic and evaluation; 21.8% physical and mental restoration; 40.5% training; 13.7% maintenance; 1% services to families; 7.5% other services; and .3% post employment services. The restoration services ranged by state from lows of 2% NY, 1.8% MN, 3.8% IA, and 3.7% CA to highs of 53.8% WV, 55.1% KY, 52.4% MS, and 48% SC. Of the $102 million restorative services, 36.3% was expended for surgery and treatment; 20.1% prosthetic and orthotic appliances; 40.9% hospital and convalescent care; and 2.7% other.

Overall, 10,163 counselor man years were involved in service delivery. Through restoration services, 119,000 had surgery and treatment, 83,000 received appliances, 51,000 had hospital care and 8,000 other care.

_____. A Summary of Selected Legislation Relating to the Handicapped: 1974. OHD 75-22002. Washington, D.C.: 1975.

The Social Security Amendments of 1972, PL 92-602, replaced separate state-run programs for the aged, blind and disabled with a single federally financed and administered program of cash assistance. Social Security benefits were increased and are received by over one million disabled persons of whom 287,000 are adults disabled in childhood.

The Rehabilitation Act of 1973, PL 93-112, completely recodifies the old Vocational Rehabilitation Act and places emphasis on expanding services to the more severely handicapped. It establishes by statute a Rehabilitation Services Administration within DHEW and authorizes states to submit a consolidated vocational rehabilitation/developmental disabilities plan.

The Education Amendments of 1974, PL 93-380, include amendment of the Education of the Handicapped Act, encouraging deinstitutionalization and normalization of educational services for handicapped youngsters.

The Housing and Community Development Act of 1974, PL 93-383, revised or rewrote every major piece of housing legislation enacted by Congress over the last 40 years. Construction and loans for housing for the elderly and handicapped, mentally or physically, are authorized.

The Rehabilitation Act Amendments of 1974, PL 93-516, contain special provisions for non-discrimination of the handicapped and require individualized written rehabilitation plans for each client.

The Social Services Amendments of 1974, PL 93-647, require that 50% of a state's allotment for federal social service funds must be used for services to AFDC, SSI, and Medicaid recipients, but prohibiting the use of these funds to support medical or remedial services which can be paid for under Medicare or Medicaid. Among the services eligible for reimbursement are training and employment services and services intended to meet special needs of the mentally retarded, emotionally disturbed, physically handicapped and addicted.

This summary includes other major legislation and other legislation benefiting the handicapped, including the Health Program Expansion Act of 1973, PL 93-45, and the Community Services Act of 1974, PL 93-644, with special attention to children with disabilities severe enough to require special education.

_____. Vocational Rehabilitation Caseload Distribution: Total, Severe and Non-severe, October 1, 1976 to December 31, 1976. Information Memorandum RSA-IM-77-66, June 6, 1977.

The caseload contraction noted in the prior fiscal year continued in the first quarter of fiscal 77. The loss in caseload volume was 5.8% compared to the same quarter in the prior year. Of all

rehabilitations, 43% were severely disabled, a gain of 1.9% over the prior comparable period. This compares to a 16.4% decline among the non-severely disabled.

US Department of Health, Education and Welfare, Social and Rehabilitation Service. Major Disabling Conditions of Clients of State Vocational Rehabilitation Agencies Rehabilitated and Not Rehabilitated During the Fiscal Year of 1969. Statistical Note No. 27. Washington, D.C.: June 1971.

Mental illness was the most common disabling condition among both rehabilitated and nonrehabilitated clients. Mental illness accounted for 23% of those rehabilitated and 39% of those not rehabilitated. Many of the conditions listed in this study as requiring physical rehabilitation, such as digestive problems and mental retardation, may also be classified as mental conditions.

_____. The Profile of Mentally Ill Persons Rehabilitated in Fiscal Year 1969. Statistical Note No. 23. Washington, D.C.: March 1971.

The weekly income of rehabilitated mentally ill persons increased as much as $58 per week. Even when the person who was treated for a mental disturbance was employed before rehabilitation, there was still an average gain in weekly income of over 10%. The gain in annual income would produce tax monies that would amortize the average cost of $581 spent on the rehabilitation of the mentally ill in under two years.

_____. A Profile of Mentally Retarded Clients Rehabilitated During the Fiscal Year of 1969. Statistical Note No. 29. Washington, D.C.: September 1971c.

Clients diagnosed as being mentally retarded had weekly income gains, of as much as $47.50, following rehabilitation. Even when the person diagnosed as mentally retarded was working prior to rehabilitation, the weekly income gain was as much as $15 or a 35% gain. The diagnosis and treatment of mentally retarded clients is therefore financially feasible, since the average cost of rehabilitation of mentally retarded clients was $678.

_____. State Data Book, Federal-State Vocational Rehabilitation Program, Fiscal Year 1972. SRS 75-25403. Washington, D.C.: n.d.

Tabular data on the 326,138 persons rehabilitated in 1972 is provided by state, by type of disability, by state earnings at referral and closure, and by other criteria. The average cost for mental conditions was $581 and for mental retardation was $678, indicating that mental disorders and mental retardation are not excessive in comparison with the average cost of all major disabling conditions of $666.

U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, Rehabilitation Services Administration. Characteristics of Clients Rehabilitation in Fiscal Years 1968-1972: Federal-State Vocational Rehabilitation Program. SRS 74-25079. Washington, D.C.: n.d.

Tabular data on persons rehabilitated over the five-year period from 1968 to 1972 is provided, together with some explanatory text and graphic illustration. "Mental illness" is considered the "major disabling condition." Breakdowns are given on services provided, occupations at closure, and other demographic data.

_____. Selected Characteristics of Clients Closed from Active Caseload Statuses, by Major Disabling Condition, Fiscal Year 1972. Statistical Note No. 43. RSA-IM-76-11. Washington, D.C.: 1975.

The average case cost of rehabilitated clients was $771 as opposed to $501 for those not rehabilitated. Mentally ill clients were more likely than other disability groups to receive services without cost to the state agency. For every dollar rehabilitated clients were earning at referral, they were earning $4.73 at closure. Case costs for mental disorder and retardation were 37% of the total for 40% of the clients rehabilitated. For mentally ill clients reporting earning, they averaged $11.43 weekly at referral and $79.44 at closure, an increase of $68.01. Comparable figures for the mentally retarded were $3.02, $53.40, and $50.38. Mean costs of rehabilitation were substantially higher for cases of blindness, asthma and hay fever, and heart disease, all over $1,000 and all common conditions.

_____. Standards for Rehabilitation Facilities and Sheltered Workshops. Rev. ed. SRS 72-25010. Washington, D.C.: 1971.

An update of the standards first issued in 1967 to encourage facilities and workshops to upgrade their program. The standards were recommended for adoption by the National Policy and Performance Council, a citizens group appointed by the secretary of the Department of Health, Education and Welfare. This 21-page booklet contains a brief preliminary section with definition of services, and standards for organizations, services, staff, clients, community relations and safety.

_____. Statistical History, Federal-State Program of Vocational Rehabilitation. 1920-1969. SRS-RSA Pub. No. 134. Washington, D.C.: 1970.

The Smith-Fess Act of 1920, the Civilian Vocational Rehabilitation Act, marked the inception of one of the oldest grant-in-aid programs for individual services. The federal-state share was 50:50. The program was intended to assist those unemployed or underemployed due to physical handicap. In 1935 the VR program was given permanent status through the Federal Social Security Act. Amendments of 1943 radically changed the VR concept extending services to the mentally ill and retarded and the furnishing of any service necessary to realize full employment potential. There was also greater federal financial participation.

Further amendments in 1954 increased the average federal participation to 60% and made grant funds available for rehabilitation research and professional training. 1965 amendments increased the federal share to a flat 75% in an effort to make services more effective and comprehensive, including employment evaluation for the severely disabled and, for the first time, construction funds for rehabilitation facilities. A National Center for Deaf-Blind Youth and Adults was established under the 1967 amendments which also authorized grants to states for services to migratory workers. The amendments in 1968 increased the federal share to 80%, broadened services to family members where necessary to rehabilitation, and established a program of vocational evaluation to serve the disadvantaged whether or not they had a mental or physical disability.

Since 1952 the case acceptance rate has consistently been around the 50% level, and since 1956, the rehabilitation rate has remained constant at about 75%. The proportion of women rehabilitated has more than tripled since 1925 from 13% to 44% and since 1935 the proportion of minority cases rehabilitated has steadily

increased from 4% to 21%. Persons referred from health oriented sources have accounted for about 30% of all rehabilitation since 1955. Since the 1943 amendments the number of mentally disabled clients has steadily risen. Placement in industrial occupations has declined to 30% of all placements.

From 1961-68 the annual aggregate earnings at closure was 5 to 6 times greater than at acceptance. At acceptance, the primary source of support for persons rehabilitated from 1964-68 was public assistance 9-11%, tax supported institution 5-8%, SSDI benefits 2-3%, and Workmen's Compensation 1.5-2.5%. Of those rehabilitated in this 5 year period about 20% had earnings at acceptance, 82% at closure. Average aggregate annual earnings in 1968 of those rehabilitated was about $3350 at closure, $2775 at acceptance. The overall per capita expenditure for vocational rehabilitation increased to $2.25 by 1969 (from 19¢ in 1950).

US Department of Health, Education and Welfare, Social Security Administration. The Size and Shape of the Medical Care Dollar. Chart Book 1975. SSA 76-11910. Washington, D.C.: 1976.

Summary data through 1974 is provided. Since the late sixties outlays for medical care have shifted notably from private to public sources. Concurrently rising health costs have outpaced overall inflation. The health industry was one of the very few for which mandatory controls were in effect for the 32 months ending 4/74. The medical care dollars share of the GNP, 7.8% in 1972 remained stable through 1974 during the Economic Stabilization Program. Of the $80 billion increase in personal health costs from 1950 to 1974, 46% can be attributed to higher costs, 15% to population growth and the 39% balance to increased use of services.

In 1974 hospital care accounted for 45% of total health costs: 34% in private care; 64% in public care. By contrast, 39% of private spending, but 15% of public spending, was for professional services. Major public program expenditures in this fiscal year were Medicare $10.7 billion (75% to hospitals, 2% nursing homes); Medicaid $10.6 billion (38% hospitals, 34% nursing homes); and all others, DOD, VA, DHEW and states, $12.6 billion (75% hospitals, 1% nursing homes). The health bill for the average aged person, $1218, was seven times that of those under 19 and almost three times that of those aged 19-64. Public funds paid 60% of the bill for the elderly but less than 30% for those under 65.

US Social Security Administration, Office of Research and Statistics. National Health Insurance Proposals; Provisions of Bills Introduced in the 94th Congress as of February 1976. SSA 76-11920. Washington, D.C.: 1976.

A tabular presentation is given, plus an outline of 18 bills. Six bills are of mixed public and private jurisdiction; five on mainly a public basis; five are tax credit measures; and two are intended for catastrophic protection. Features of several of the bills are detailed in the text.

_____. Independent Health Insurance Plans in 1974. Research and Statistics Note No. 21. Washington, D.C.: November 30, 1976.

Income from over 12 million subscribers amount to 8% of all private health insurance business in 1974. The largest of the consumer-sponsored, non-profit plans are the Kaiser Foundation Plans and the Health Insurance Plan of Greater New York City, both group practice plans, and Group Health Insurance of New York City, an individual practice plan. The six Kaiser Plans and the Health Insurance Plan serve more than 3 million people; the Group Health Insurance has a 1.8 million enrollment. The big, individual practice plans in the rubber, postal, and mining industries are self-insured employer-employee plans for more than 2 million members. There are hundreds of smaller community based plans. As of October 1974, a total of 142 HMO's were reported by the Health Services Administration (DHEW).

US Interdepartmental Workers' Compensation Task Force. Policy Group. Workers' Compensation: Is There a Better Way? Report submitted to Congress, January 17, 1977.

This report on the need for reform in state workers' compensation assesses progress since the 1974 Report of the National Commission on State Workers' Compensation Laws. The policy group reaffirms a recommendation of the Commission: that the state workers' compensation agency should oversee rehabilitation and re-employment of job injured/disabled employees. California adopted legislation to this effect in 1976.

Medical only and temporary disability claimants represent 95% of the cases and are handled well. Occupational disease, work related death and permanent disability are problems often not satisfactorily resolved. The latter two constitute 5% of claims but 50% of benefit payments. At present, to receive compensation

the worker must establish disability . . . "rehabilitation is known to be more effective when started immediately after injury, and the mental state of the patient is very important to its success." In contrast however, 39% of permanent partial and 52% of permanent total disability cases are litigated with an average delay of payment of 134 days.

One of the group's major recommendations seeks systemic change in state programs to heighten rehabilitation efforts. Compensation for wage loss should be separated from other benefits with wage replacement benefits paid as wage loss accrues. Implementation could increase state vocational rehabilitation delivery of reimbursable services from workers' compensation, the first social insurance system developed in this country.

US National Commission on State Workmen's Compensation Laws. "The Medical Care and Rehabilitation Objective," in National Commission Report on State Workmen's Compensation Laws. Washington, D.C.: US Government Printing Office, 1972, pp. 77-85.

It is "important to prepare patients psychologically for recovery of their capabilities and morale." Among 84 recommendations for improvement of worker's compensation, nineteen considered essential, the Commission recommended that the worker be permitted the initial selection of his physician; that there be no statutory limits of time or dollar amount for medical care of physical rehabilitation services for any work-related impairment; and that there be no arbitrary limits by regulation or statute on the types of medical service or licensed health care facilities that can be authorized.

The Urban Institute. Executive Report on the Performance Standards of the Vocational Rehabilitation Program. Jerry Turem, Project Director. Washington, D.C., (1976).

The summary conclusion is that the performance measures of present VR standards do not enable a judgment of the efficacy of state programs. The Congressional priority for the severely handicapped and past HEW emphasis on public assistance recipients were choices made with little consideration of cost effectiveness or effects upon the program as a whole.

Evaluation has been an inherent and essential aspect of the program over its 56 years from 1920. The pressures of World War II generated expansion to include the mentally ill and blind, and

to include a wide range of medical and related services. Program Administration Reviews (PAR's) were not begun on a national level until 1958. The 1975-76 PAR's also added Social Security disability insurance beneficiaries (SSDI and SSI) as priority considerations. The first formally funded authorization for evaluations came in 1968, and as of 1973 they are conducted by persons not immediately involved in program administration. The Secretary's standards for evaluation were published in December, 1975.

The turn-around reporting time of states varies widely. Critiques have emerged ranging from services to persons with no disability, to demonstration that cases denied by state agencies can be rehabilitated by expenditures on the order of 5 to 20 times that normally spent. The intermediate goals of developing self-care ability, improved mobility, psycho-social adjustment to disability, etc., are not measured, nor is attention given to the need for post-employment services.

Few states apparently do much to organize priorities. It is first-come, first-served, until resources run out. The potential target population is not delineated. The success rate for different client disability groups should be known with closer precision.

Emphasis should be placed upon acquisition of "similar benefits," that is, financial assistance available to the handicapped from programs other than VR. Because of the wide variation in state circumstances, comparison to national averages seem fairly useless, but calls for the establishment of state standards. The current emphasis upon serving the most severely handicapped creates substantial program tension since the probability of successful employment is lower. Yet, the legislative history calls for the maximum number of outcomes to be in the competitive employment category.

The Urban Institute. Report of the Similar Benefits Study to the Department of Health, Education, and Welfare. Jerry Turem, Project Director. Washington, D.C.: August 1976.

The main objective of the study was to identify and evaluate administrative procedures and policies employed by state vocational rehabilitation agencies to facilitate the utilization of other programs in the provision of rehabilitation services to their clients.

Wallace, H. "Handicapped Children Under National Health Insurance," Developmental Medicine and Child Neurology 18, 1976: 213-228.

Features of Britain's National Health Service initiated in 1948 and Sweden's National Health Insurance begun in 1955 are described. Both have a regionalization model, and very comprehensive preventive, health and educational services available to children. The objective clearly is to normalize the life of such children. Operative details are provided for both programs.

Since the Social Security Act of 1935, each state has had an official crippled children's program. By 1972 they cared for 513,000 handicapped children and youth. The author is of the opinion that any US health insurance program will include payment for the services of handicapped children and youth either by virtue of comprehensive care for all, or catastrophic coverage. Current state program roles could change including being a third party provider for VR. The experience of Britain and Sweden suggests that certain specific services will continue to need special support.

Weikel, K. and Leamond, M. "The Decade of Medicaid." Public Health Reports 91, 1976: 303-308.

Dependent upon state per capita income, the federal matching is 50% to 78% of state Medicaid costs. Operational weakness, dramatically escalating costs and recipient and provider fraud have brought increased scrutiny.

The 1935 Social Security Act marked the beginning of the American Social Welfare system for: a) social insurance--unemployment insurance, workers' compensation, guaranteed pension, and b) public assistance direct financial aid provided by states for those unable to work.

The 1950 amendments expanded the categories of public assistance and provided a federally supported program of direct vendor payments. In 10 years, 40 states had matching plans. The Kerr-Mills Act of 1960 established the category of medically needy and more open-ended federal matching. By 1965, all 50 states were participating. Medicaid was the "sleeper" of 1965 legislation. Hastily written, its ambitious goal was to provide the poor the same access as the rich to mainstream medical care. Thirty-two state programs now cover the medically needy in addition to welfare recipients.

Amendments were introduced to Medicaid in 1967 and again in 1972 reflecting Congressional disenchantment. States were permitted to introduce cost-sharing for the medically needy and for optional services to categorical recipients. Services were to be reviewed to determine whether "medically necessary." It has been found that once a state shows it can detect fraudulent and abusive practices they rapidly decline. There is inequity among states. Persons who may receive benefits in one state may not be eligible in another. Also, there was little recognition that Medicare's incomplete coverage for long term care would require Medicaid to devote about 40% of its funds to long term care.

During its first 10 years, Medicaid dramatically improved the financial access of the poor to medical services. Currently the poor are using health services at about the same rate as the non-poor. In 1974 alone, more than 21 million received at least one service under Medicaid. There are currently two opposite pressures. One would consolidate Medicaid and the 15 categorical programs into a block grant to states, the other would replace Medicaid with a uniform national program for 35 million low income persons.

White Paper on Workers' Compensation: A Report on the Need for Reform of State Workers' Compensation. Prepared by US Departments of Labor; Commerce; Health, Education and Welfare; and Housing and Urban Development, May 13, 1974. GPO-875-745. Washington, D.C.: US Government Printing Office, 1974.

Each year two million employees miss one or more days of work due to work-related injury or illness, and the cost of state workers' compensation programs was $6 billion in 1973. Occupational disease concepts are being broadened from those that are more prevalent in certain occupations and those that occur frequently in the general population, but that can be aggravated by work conditions. Only the largest firms, which tend to have low accident rates, can afford self-insurance, and only one-quarter of all firms subject to workers' compensation are experience-rated. Available evidence indicates that VR is more cost-effective for workers' compensation claimants than for the general population of federal-state VR programs. On the average, the net economic benefit of rehabilitation services to workers injured in 1965 to 1966 was $15,200 (in 1966 dollars). Compensation laws have largely removed fault as an element of controversy.